University of Alberta

DEVELOPING RESILIENCE: HOW WOMEN MAINTAIN THEIR HEALTH IN NORTHERN GEOGRAPHICALLY ISOLATED SETTINGS

by

Beverly D. Leipert ©

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Developing Resilience: How Women Maintain Their Health in Northern Geographically Isolated Settings* submitted by Beverly D. Leipert in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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DEDICATION

I dedicate this dissertation to the advancement of the health of women who live in geographically isolated settings. May this work contribute to improved health and health care for and by these women.

Women's health includes emotional, social, cultural, spiritual and physical well-being, and it is determined by the social, political and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs about and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by that woman herself, to her full potential.

- Phillips (1995, pp. 507-508)

The health of rural women has been a neglected topic in the nursing literature...Environmental factors can be health promoting as well as detrimental to health...Sensitivity to rural health care delivery issues, awareness of the health beliefs of rural residents, as well as exposure to the rural lifestyle in a geographical area will go a long way to help nurses effectively plan and provide holistic care for women who live there.

- Bushy (1994, pp. 67, 68, 72)

ABSTRACT

The health of women who live in northern geographically isolated settings in Canada has not been studied in a clear, comprehensive, and focused manner. The purpose of this study was to explore how women perceive and maintain their health in northern geographically isolated settings. A feminist grounded theory method guided the study. Data were collected through semi-structured interviews with 25 women who had lived a minimum of two years in northern BC and who were 20 years of age or older. Data were analyzed using the constant comparative method of grounded theory, assisted by the use of the NVIVO qualitative data management computer program.

The main problem for the women in this study was revealed to be that of *vulnerability* to health risks. The health risks that women were vulnerable to included *physical health and safety risks, psychosocial health risks,* and *risks of inadequate health care*. Vulnerability to health risks resulted from *marginalization* within the northern context. This marginalization was characterized as including *physical and social isolation, limited options of goods, services and education, limited power,* and *being silenced.*

Women responded to health vulnerabilities by *developing resilience* which included strategies of *becoming hardy, making the best of the north,* and *supplementing the north.* Becoming hardy for northern women involved taking a positive attitude, following spiritual beliefs, developing fortitude, and establishing self-reliance. Women made the best of the north by participating in northern activities, making decisions about health care services, seeking education and information, seeking and receiving social support, and working on financial and work issues. Supplementing the north involved being political, and leaving the north, temporarily or permanently. The degree to which women could develop and use resilient strategies was affected by women's location within the northern context, the degree of marginalization and vulnerability they experienced, and their personal resources. As a result of developing resilience, women experienced *consequences* of *thriving, surviving,* and *declining* in behavioral, cognitive, and emotional domains.

The study concludes with *implications* for women's health research, health care practice and health-related policy, and health practitioner education.

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I gratefully acknowledge the Izaak Walton Killam Memorial Scholarship awarded to me by the University of Alberta. This award supported my travel to interview women in distant northern communities and it provided funding for the purchase of an NVIVO qualitative data management computer program. Because of this award, I was more readily able to obtain rich data and engage in data analysis in an enhanced manner. This dissertation is much enriched by my receipt of the Killam Scholarship, and I thank the University of Alberta and the Faculty of Nursing most sincerely for this award.

I also acknowledge the women in the north who generously gave their time and insights to this research. Their thoughtful perspectives, commitment to the research, and kind hospitality enriched the depth and scope of my understanding of the grounded realities of life in the north. I was privileged to meet these resilient women and share in their experiences.

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TABLE OF CONTENTS

CHAPTER I: INTRODUCTION 1
- Conceptual Approach of the Study 2
- The Research Problem 6
- Purpose of the Study 9
- Research Questions 9
- Significance of the Study 9
- The Researcher's Assumptions 11
- Summary 12

CHAPTER II: PRESENT STATE OF KNOWLEDGE 13
- Rural and Northern Settings 13
  - Rural Perceptions of Health 16
- Women's Health in Geographically Isolated Settings 18
  - Women's Perceptions of Health 19
    - Canadian Women's Perceptions of Health 19
    - Women's Perceptions of Health Outside of Canada 22
  - Priority Areas for Women's Health in Geographically Isolated Settings 24
    - Violence Against Women 24
    - Economic Insecurity and Work-Related Issues 25
    - Access to Health Services 28
    - Social Support Issues 29
  - Health Needs of Special Groups of Women 30
- Summary 32

CHAPTER III: RESEARCH METHOD 34
- Theoretical Underpinnings of the Research Method 34
  - Symbolic Interactionism 34
  - Grounded Theory 35
  - Feminist Inquiry 38
  - Feminist Inquiry and Grounded Theory 42
- Ethical Considerations 45
- Sampling 47
- Data Collection 49
  - Interview Process and Protocol 51
- Analysis 56
  - Open Coding 57
  - Selective Coding 58
  - Theoretical Coding 60
  - Memoing 64
- Strategies to Ensure Rigor 65
  - Grounded Theory Strategies 66

        Feminist Research Strategies 68
    Summary 76

CHAPTER IV: FINDINGS: THE SAMPLE, THE THEORY, AND THE NORTHERN CONTEXT 77
    The Sample 77
    A Brief Overview of the Theory 79
    The Northern Context 81
        Historical Location 81
            Resource-Based Economies 82
        The Physical Environment 84
            Geographical Location and Definition 84
            Positive Elements 87
            Negative Elements 90
        The Sociocultural Environment 92
            Positive Elements 93
            Negative Elements 94
        The Political Environment 96
            Undervaluing of the North 96
            Undervaluing of Women 100
                Undervaluing of women's roles and perspectives . . . 100
                Attitudes of physicians 102
        Summary 105

CHAPTER V: FINDINGS: MARGINALIZATION 106
    Isolation 106
        The Physical Environment 106
        The Social Environment 108
            Isolating Women from Others 108
            Creating Insider/Outsider Status 110
    Limited Options 112
        Goods 112
        Services 113
            Traditional and Alternative Health Care Services 114
                Availability of physicians and nurses 114
                Quality of care 117
                Availability of hospital, diagnostic, and mental health services 122
                Accessibility of alternative health care services 125
            Health Promotion and Disease Prevention Services 128
                Health education 128
                Parenting support 131
                Relationship support 133
                School health 135
                Social services 136

            Other Services and Resources 137
                Arts and recreation 137
                Technology 139
        Education 141
            The Value of Education 141
            Sources of Education 143
    Limited Power 146
        Power Delimited by Geography and Gender 147
    Being Silenced 150
    Summary 156

CHAPTER VI: FINDINGS: VULNERABILITY 157
    Physical Health and Safety Risks 157
    Psychosocial Health Risks 161
        Threats to Well-Being 161
        Abuse 162
        Social and Mental Health Issues 164
    Risks of Inadequate Health Care 168
        Difficulty Getting to Resources 168
        Inadequate and Inappropriate Resources 170
            Limited Diagnostic and Treatment Resources 171
            Inadequate Menopause and Mental Health Resources 173
            Limited Alternative Therapies 175
            Inappropriate Provider Attitudes 176
    Summary 178

CHAPTER VII: FINDINGS: DEVELOPING RESILIENCE 180
    Strategies of Resilience 181
        Becoming Hardy 181
            Taking a Positive Attitude 182
            Following Spiritual Beliefs 184
            Developing Fortitude 186
                Being committed 187
                Learning from previous experience 188
            Establishing Self-Reliance 190
            Theoretical Perspectives of Hardiness 193
        Making the Best of the North 194
            Participating in Northern Activities 195
            Making Decisions about Health Care Services 196
            Seeking Education and Information 199
                Universities and community colleges 200
                Nurses and physicians 201
                Community education programs 202
                Distance education 202
            Seeking and Receiving Social Support 203

      Unique aspects of social support in the north 204
      Functions of social support 205
      Sources of social support 208
    Working on Financial and Work Issues 210
      The nature of women's work in the north 210
      Managing financial insecurity 214
      Managing employment-related problems 216
  Supplementing the North 220
    Being Political 220
      Valuing feminism 220
      Personal advocacy 222
      Community advocacy 223
    Leaving Temporarily 226
    Leaving Permanently 230
Summary 233

CHAPTER VIII: FINDINGS: CONSEQUENCES OF NORTHERN WOMEN'S RESILIENCE 235
Thriving 237
  Behavioral Thriving 237
  Cognitive Thriving 238
  Emotional Thriving 240
Surviving 242
  Behavioral Surviving 243
  Cognitive Surviving 244
  Emotional Surviving 245
Declining 247
  Behavioral Declining 247
  Cognitive Declining 250
  Emotional Declining 252
Summary 254

CHAPTER IX: DISCUSSION 256
Summary and Conclusions 256
Discussion of the Findings and Recent Literature 258
  The Centrality of Resilience to Northern Women's Health 258
    Women's Health and Resilience Within the Northern Context 258
    Theoretical Perspectives of Resilience 262
      Resilience 263
      Vulnerability 266
      Marginalization 268
  The Need for Enrichment of Societal and Institutional Structures in the North 270

        The Importance of Feminist Qualitative Methods in Research Related to Northern Women's Health 273
    Study Limitations 275
    Implications 278
        Women's Health Research 278
        Health Care Practice and Health-Related Policy 281
        Health Practitioner Education 285
    Conclusion 286

REFERENCES 288

APPENDICES

Appendix A: British Columbia Health Regions 310
Appendix B: Ethical Principles for the Conduct of Research in the North . 311
Appendix C: Letters of Permission from Ethics Boards 322
Appendix D: Information for Informed Consent for Interviews 327
Appendix E: Informed Consent Form for Interviews 329
Appendix F: Consent Form for Permission to Take Photographs 330
Appendix G: Recruitment Invitations 331
Appendix H: Initial Contact Form 333
Appendix I: Background Information Form 334
Appendix J: Initial Interview Guide 335
Appendix K: Field Notes Recording Form 336
Appendix L: Individual Participant Characteristics 337
Appendix M: The Northern Women's Health Gathering 338

TABLES

Table 1: Sociodemographic Information about Study Participants 78
Table 2: Consequences of Resilience 236

FIGURE

Figure 1: Developing Resilience: Northern Women's Process of Maintaining Their Health 80

CHAPTER I

INTRODUCTION

How women stay healthy in northern or other geographically isolated settings in Canada has received little research attention. In particular, there is little information from the perspectives of women themselves about health in relation to the geographical context in which they live. This study seeks to examine from the perspectives of women how women stay healthy in one geographically isolated setting, northern British Columbia (BC).

Northern British Columbia is characterized by a large geographic area with population and resource profiles similar to other isolated northern areas that are comprised of both rural and urban communities. The northern area of BC includes the Cariboo, Skeena, Peace River, and Northern Interior health regions (Report of the Northern and Rural Health Task Force, 1995) (See Appendix A). Northern geographically isolated settings in BC include rural and urban locations. Characteristics of the northern areas of this province include predominantly younger aged populations that are sparsely scattered over wide distances, a single resource base that is vulnerable to changes in the economy, small communities that are separated by challenging geography and climate, large Aboriginal populations, and difficulty in gaining access to health, education, and social services based in urban areas, predominantly in southern parts of the province (Report of the Northern and Rural Health Task Force, 1995).

In 1994, the BC Minister of Health appointed a Northern and Rural Health Task Force to determine the health needs of residents of remote and rural communities in BC and to identify feasible ways to address these needs. The Task Force (1995) based its study and report of women's health on a previous study done by the British Columbia Women's Hospital and Health Center Society (1995), and devoted only two pages of its 126 page report to women's issues. In these two pages, a number of recommendations were made related to health issues of women living in remote and rural communities. These recommendations included the need to increase program access and the use of technology to reach women, and the need to study regional differences related to women's health. In addition, the report identified several priority areas for women in remote and rural areas in BC. These priority areas included: (a) the need for women's participation in policy and planning, (b) the need for advocacy and policy direction, (c) increased public education and awareness of women's health issues, (d) accessibility issues, (e) the need for increased availability of sensitive and accessible health materials, (f) the need for increased attention to inequalities and human rights issues in women's lives, (g) enriched sensitization and training of health care workers, (h) the need for holistic health approaches with appropriate de-medicalization, and (i) the need for outcome evaluation to ensure women's health issues are addressed. The report concluded its discussion of women's health issues by recommending that gender differences in health in remote and rural areas be studied, that social and economic determinants of women's health be addressed, and that the needs of women in remote and rural areas be addressed in research and services. From this report, it is apparent, then, that the health of women who live in geographically isolated areas such as in northern British Columbia requires research investigation. Such investigation can help to support program, practice, and policy initiatives that will effectively support the health needs and strengths of northern women.

Conceptual Approach of the Study

In this section, I discuss the conceptual approach that orients and informs this study of women's health in geographically isolated settings. Within the context of health promotion, this study is based on a socioenvironmental approach (Labonte, 1993) to health that recognizes the influence of broad determinants of health, specifically the determinants of environment and gender (Health Canada, 1996). Health promotion has been defined as "the process of enabling people to increase control over, and to improve, their health" (World Health Organization, 1986, p. 1). A comprehensive examination of health promotion considers two focuses: a micro focus at the level of individual action, and a macro focus where the emphasis is on understanding and taking collective action on the social and environmental influences on health (MacDonald, 2001a; Raeburn & Rootman, 1998).

Beginning in the 1980s, the health promotion community in Canada began to discuss factors beyond the health care field that could lead to improvements in health (Health Canada, 1996). The contribution of medicine and health care to improved health was recognized as limited, and it was concluded that spending more on health care would not result in further improvements in the health of Canadians (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). Rather, multiple factors, labeled determinants of health, and interactions among these factors, are now thought to determine health (Canadian Public Health Association [CPHA], 1997; Federal, Provincial and Territorial Advisory Committee on Population Health; Health Canada; Hertzman, Frank, & Evans, 1994). Determinants of health include a variety of factors such as social and economic environments, physical environments, health services, biological influences, and health behaviors and skills (CPHA). The determinants of culture and gender have recently also been identified as important for health (Health Canada). The environmental and gender determinants of health have particular relevance to this study because it takes as its focus the exploration of women's health and geographical context.

Increasingly, women's health agendas and nursing practice have focused on the socioenvironmental determinants of health (Registered Nurses Association of British Columbia, 1994; Reutter, Neufeld, & Harrison, 2000; Woods, 1995). A socioenvironmental approach to health shifts the emphasis from an individual (behavioral) perspective to a social perspective that emphasizes material and social conditions in which people live (Labonte, 1993). In this approach, a range of psychosocial risk factors and socioenvironmental conditions provide the context for individual health behaviors (Labonte). For example, risk conditions such as poverty, low education, sexism, and low political and economic power may lead to risk factors such as isolation, poor social support, low self-esteem, and low perceived power. In turn, these risk factors may lead to behaviors such as smoking or substance abuse, with resulting morbidity or mortality.

The underlying premise of the influence of the social environment on health is that the array of values, norms, practices, and policies of a society influence in varying ways the health and well-being of individuals and populations (Corin, 1994; CPHA, 1997; Health Canada, 1996). Supportive social environments can encourage and enable healthy choices and lifestyles, as well as people's knowledge, intentions, behaviors, and coping skills in dealing with life in healthy ways (Health Canada). In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids health risks (Health Canada). Support from family, friends, and communities also seems to act as a buffer against health problems (CPHA). This support helps people solve problems, deal with adversity, and maintain a sense of mastery and control over life circumstances (CPHA).

However, social environments can also be health inhibiting (Corin, 1994; CPHA, 1997). Values, norms, practices, and policies may create social barriers that interfere with access to environments and resources that support health. In the United Kingdom, Corin found that a traditional way of life evident in rural communities could be simultaneously protective and debilitating for women. The effects of activities that women engaged in, such as crafting and churchgoing, depended upon how these activities were viewed within the larger social collective. In BC, the Provincial Health Officer (1996) noted that women receive less pay for the same work as men, are more likely to be victims of violence and to live in poverty, and are under-represented in decision-making bodies. As a result, women do not enjoy optimum access to health and health supporting environments. However, the influence of social environmental factors on the health of women in geographically isolated environments remains unknown. This study seeks to investigate the influence of social environmental factors on the health of women in northern BC environments, from the perspective of women in these environments.

The physical environment determinant of health refers to factors in the natural environment, such as air and water quality, that may influence health (Hertzman, Frank, & Evans, 1994). Factors in the human-built environment such as housing, workplace environments, and community and road designs are also important for health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994; Health Canada, 1996). In northern BC, forestry and other resource-based employment frequently results in environmental pollutants. Therefore, the quality of air and water is of particular concern to northern residents. Other physical environmental factors in northern BC such as climate, rugged terrain, and vast distances between communities also pose challenges to people's health. For example, the vast distances and challenging terrain characteristic of northern BC contribute to physical and social isolation which can adversely affect health. This study will explore the influence of these and other physical environment determinants of health on the health of northern women.

Gender, a newly designated determinant of health, is defined by Health Canada (1996) as "the array of socially determined roles, personality traits, attitudes, behaviors, values, relative power and influence that society ascribes to the two sexes on a differential basis" (p. 17). Women, by virtue of the gendered norms in society, have been subordinated, inhibited in their achievement of political, cultural, social, and economic equality, and consequently impeded in their attainment of optimal health status (Health Canada). Gender inequities in health are evident in a report on the health of British Columbians, including a persistent undervaluing of women, a gender wage gap, and the provision of unnecessary interventions (Provincial Health Officer, 1996). This study recognizes the importance of gender as a determinant of health by focusing on women's perceptions of their health and ways that women stay healthy. In addition, a feminist approach is used in this study as a way to explore gendered ways of experiencing health in northern BC.

In summary, within the context of health promotion, this study focuses most explicitly on the health determinants of social and physical environments, and gender. However, a major premise of the socioenvironmental approach to health is that health is determined by interactions among all of the determinants of health, including the determinants of income, health services, biological influences, culture, and health behaviors and skills, in addition to the social and physical environments and gender

(Health Canada, 1996). Therefore, interactions among these determinants of health will be explored in this study as they apply to the health of women in geographically isolated settings.

The Research Problem

The health of women in Canada has received increasing attention over the past twenty years. In the past, women's health was largely conceptualized in terms of biological, gynecological, and child care factors (McMurray, 1994). However, with the increased body of knowledge from feminist scholars, there has been a shift in attention to the examination of women's experiences in relationship to their social, emotional, spiritual, and physical environments (McBride, 1992). Increasingly women's health is understood to be affected by factors of a more diverse nature, such as income, social support, attitudes and values, socialization, power, and representation issues (National Forum on Health, 1997), in short, by the determinants of health identified above. Indeed, social, environmental, and economic factors and gender are determinants of health that may have particular impact on the health of women in Canada (National Forum on Health; Report of the Northern and Rural Health Task Force, 1995). Women are at greater risk of poverty than men because women's earnings are lower than men's, women are less likely to be employed than men, and women are more likely to be working part-time (National Forum on Health). Thus, women are less likely to be in a position of power and enjoy fewer career opportunities than men. In BC overall, more women are at the lower end of the earning scale (30 percent) compared to men (16 percent) (Report of the Northern and Rural Health Task Force), and one quarter of all women and almost half of single mothers live in poverty (Provincial Health Officer, 1996). However, the impact of gender, economic, social, and environmental factors on the health of women in northern BC remains unclear.

In addition, little research has explored possible health enhancing behaviors of women, such as their skill in developing social support networks, their enhanced communication skills, their greater willingness to seek assistance, and their greater aptitude for caregiving (Provincial Health Officer, 1996). As these factors could contribute to better health and improved quality of life for women, they merit further study.

Study of the influence of geographical context on health is increasingly being acknowledged as central to a more comprehensive understanding of women's health in Canada (National Forum on Health, 1997; Walters, Lenton, & Mckeary, 1995). However, the health of women who live in geographically isolated settings has received scant research attention. McMurray (1994) noted that there remains a gap in our knowledge of rural women and rural women's health issues. For example, in a study completed in 1997 wherein I examined women's health and public health nursing practice in northern BC, it was revealed that public health nurses had limited knowledge about how women in northern communities maintained their health (Leipert, 1999). Other research has documented some aspects of the health status of rural or farm women (Statistics Canada, 1995; Young, 1997). However, the health status of women in northern Canadian settings and how these women perceive and maintain their health are topics that are virtually unexplored. Knowing how women in isolated settings perceive and maintain their health would facilitate the development and implementation of effective health promotion and illness and injury prevention programs for women in these settings (Bushy, 1993, 1994; MacCormack, 1992). Client perceptions of health assist health care professionals and others to understand client motivation, knowledge, and abilities regarding health and health care (Long, 1993). Such understanding is important for the development of strategies that are both relevant and acceptable to the client (Long).

Much of the research to date has examined the health of women using quantitative research approaches (Wuest, 1997a). Much of the traditional survey research, a widely used quantitative approach upon which much of Canadian health policy is based, has not considered gender differences in health experiences or environmental influences on the health of women (Clarke, 1992; Wuest). Because these approaches silence the voices of women and are seen to be context-stripping, they provide a limited picture of the experience of women's health (Reinharz, 1992).

Conversely, qualitative approaches acknowledge the importance of context and allow women's values and perspectives to be heard directly (Reinharz). In addition, qualitative research can provide rich and thick descriptions and explanations of processes that occur in context (Morse & Field, 1995). Thus, qualitative approaches, such as the grounded theory method used in this study, provide in-depth data and understanding that can effectively inform policy, practice, and research initiatives (Status of Women Canada, 1996; Ward, 1995).

The need for feminist research in the area of women's health is acknowledged by authors in several disciplines (Chinn, 1995; Devault, 1990; Reinharz, 1992). Feminist research, which tends to use more qualitative approaches to allow women's perspectives and voices to be heard (Reinharz), is valuable in the exploration of women's health issues in several ways. A feminist approach helps move the view of women beyond the narrow scope of women's reproductive capabilities and issues to a broader, more context-based perspective (Chinn). Feminist research, by its consciousness raising processes and consequences, can also facilitate emancipation for women, as citizens, health care clients, and health care providers (Sampselle, 1990; Woods, 1995). In addition, a feminist perspective promotes a focus on issues that are important to women, the examination of women's experiences as they define and interpret them, and the development of strategies from women's standpoints to effectively address their health issues (Campbell & Bunting, 1991; Seibold, Richards, & Simon, 1994; Webb, 1993). As a result, research that embraces a feminist approach, such as this study, holds much promise in its ability to effectively discover knowledge that addresses women's health needs.

In summary, there is a need to examine women's health and the processes women use to maintain their health in geographically isolated settings in northern BC. To date, the study of women's health in Canada has been primarily limited to quantitative approaches and to urban and non-northern perspectives. This study seeks to address women's health and women's processes of maintaining their health in northern BC from the perspectives of northern women.

Purpose of the Study

The purpose of this study is to examine how women perceive and maintain their health within geographical, social, economic, and other contexts in northern BC.

Research Questions

The following research questions guided this study:

1. How do women who live in northern BC perceive health?
2. How do women in northern BC maintain their health?
3. How does the context - geographical, social, economic, etc. - influence the health of women who live in northern BC?
4. What recommendations do women have for enhancing the health of women in northern BC?

Significance of the Study

Results generated from this research will contribute to knowledge development in the areas of women's health in rural, northern, and other isolated contexts. The results will assist women who live in isolated contexts to better understand their circumstances and to work individually and collectively toward the betterment of conditions influencing their health. The results from this study also will contribute to understanding of women's health in isolated settings by others, such as women's partners and families, legislators, and health care practitioners. Such understanding could contribute to changes in policies and programs that will strengthen the health of women in geographically isolated settings. In addition, results from this study could inform educators and researchers who work in the area of women's health. Educators may be better able to facilitate appropriate learning about women's health in geographically isolated settings using the findings of this study. As this study is opening up a new area of research, results could be informative for future research endeavors. The study findings may help to highlight gaps in knowledge and other important areas for future research regarding women's health within a northern context.

It is anticipated that results from this study could also contribute to the health of women in geographically isolated settings that are not situated in northern locations, such as in rural prairie locales. This study could also facilitate understanding in other situations where people are isolated, for example, understanding of issues for physically challenged individuals who live in urban areas but who are physically isolated in their communities.

This study also has important implications for the development of nursing knowledge, theory, and practice. Most nursing theory addresses the four metaparadigm concepts of person, health, environment, and nursing (Woods, 1995). This study, with its focus on northern geographically isolated settings, seeks to address the concept of environment. The environment has been a major concept in the domain of nursing knowledge since the time of Florence Nightingale (Meleis, 1997). However, nurse theorists generally regard the environment either as the immediate surroundings or circumstances of the client or nurse, or as an interactional field to which individuals adapt, adjust, or conform (Kleffel, 1991). This perspective on the concept of environment is limited and keeps nursing from examining the relationships of social, political, economic, and cultural conditions that produce health and illness (Kleffel). In addition, this limited view of the environment excludes nursing from the mainstream arenas where these broad environmental issues are addressed and does not facilitate nursing practice that adopts an upstream thinking point of view that focuses on modifying economic, political, and environmental factors (Anderson, 1993; Kleffel; Stevens, 1989). For example, a limited understanding of environment limits nursing activities such as the effective and comprehensive assessment of broad community needs and the planning and implementation of health promotion programs at the community or societal level (Anderson). A nurse with a limited view of the environment may overlook issues related to societal power and oppression when assessing the health needs and capabilities of clients (Kleffel; Stevens). In addition, a limited understanding of environment restricts the scope of nursing practice to individual level interventions; interventions at the broader policy level tend to be excluded when nursing subscribes to a limited perspective of environment (Kleffel; Stevens).

Nurses have been urged to take on the roles of assisting clients to more fully understand their realities and their positions within them so that clients can develop their potential and change structural conditions that contribute to vulnerability, rather than be limited to adaptation to unhealthy circumstances (Moccia, 1988; Reutter, Neufeld, & Harrison, 1995). These types of roles require that nurses extend their conceptualization of environment, enrich their knowledge about environmental relationships to health and illness, and direct nursing practice to prevention and health promotion as well as curative care (Kleffel, 1991; Reutter, Neufeld, & Harrison). This study enhances understanding of client realities and relationships to environment by focusing on a broad conceptualization of environment and by using a feminist grounded theory method that focuses on women's perceptions and sociopolitical factors.

The Researcher's Assumptions

Harding (1983), a feminist philosopher, stated that when undertaking feminist research, the researcher's own perspectives and assumptions must be identified to locate the researcher within the research. I therefore include here a brief summary of my perspectives and assumptions as they relate to this feminist project. My perspectives and assumptions, based as they are on certain values, originated in my experience growing up in rural Saskatchewan. At any early age, my mother was widowed and left with three children and a farm. I observed the effects of sexist attitudes and behaviors on my mother's health as she struggled to reconstruct her life and the lives of her children. I learned through experience about the importance and necessity of being a strong and independent woman, and the challenges to achieving this independence in a patriarchal world. In my work as a public health nurse in rural Saskatchewan, I observed first hand the effects of the rural context on the health of the women with whom I worked. Presently, as the relative of two women who live in rural areas, and as a woman who lives in an isolated northern setting, I am encouraged to continue my consideration of the effects of isolated settings on the health and lives of women in Canada. I therefore summarize my assumptions as follows: (a) women's knowledge, experiences, and beliefs are frequently ignored, undervalued, and denigrated by society at large; (b) women have important knowledge, experiences, and beliefs that need to be heard; (c) the articulation and valuing of women's knowledge, experiences, and beliefs require political action by, for, and with women; and (d) women's knowledge, experiences, and beliefs are inherent in and important for the development of nursing knowledge and practice.

Summary

In this chapter, I have discussed the conceptual approach to the study, the research problem and purpose of the study, the research questions, the significance of the study, and my assumptions as the researcher. I turn in the next chapter to a discussion of the present state of knowledge, as revealed in the literature.

CHAPTER II

PRESENT STATE OF KNOWLEDGE

The present state of knowledge regarding the topic for this study was determined by reviewing literature from the disciplines of nursing, public health, sociology, psychology, education, women's studies, and medicine. Criteria that guided the selection of the literature included: (a) it must address women's health or geographical isolation; (b) it is relevant to the Canadian context; and (c) it is current, in general published between 1990 and the present, although literature published prior to this time frame was also retrieved and reviewed if it appeared to be relevant. Although the primary focus was on literature that addressed the Canadian scene, supplemental relevant literature from an American perspective was also considered. American literature was included because of some relevant similarities between Canada and the United States, and because of the limited literature available in certain areas of the search (e.g., the discussion of geographical isolation). A paucity of literature exists that specifically examines health issues in northern geographical settings. Therefore, this review highlights the slightly more prevalent rural literature as one aspect of northern geographical isolation.

The literature review is organized under two major headings: *Rural and Northern Settings*, and *Women's Health in Geographically Isolated Settings*. Aspects of each of these two major headings will be addressed. *Rural Perceptions of Health* will be discussed in the Rural and Northern Settings section. In the section Women's Health in Geographically Isolated Settings, I will discuss *Women's Perceptions of Health, Priority Areas of Women's Health in Geographically Isolated Settings*, and *Health Needs of Special Groups of Women.*

Rural and Northern Settings

In this section, conceptualizations of rural and northern are addressed. Rurality is considered in this study because aspects of ruralness, such as geographical isolation, are also inherent in northern locations. In Canada, the distinguishing feature between rural and northern is that northern settings are more isolated and have more severe climatic conditions. However, no universal definition of 'northern' exists. Nevertheless, one source (Report of the Northern and Rural Health Task Force, 1995) has described characteristics often found in northern communities in BC. Some of these characteristics include: small population centers with large distances between them; predominantly young populations; strong influence of geography and climate on daily life; single resource-based economies with resultant vulnerability to economic changes; decreased access to health, education, and social services; lower average education; and a practice of competing with other rural communities for scarce resources. It must be noted that many of these characteristics apply to rural locales as well. In BC, 'northern' has been specified to include four health unit regions: Cariboo Health Unit, Northern Interior Health Unit, Skeena Health Unit, and Peace River Health Unit (Report of the Northern and Rural Health Task Force) (Appendix A).

Similarly, the literature revealed that no universal definition exists for the term 'rural' (Fitchen, 1991; Keating, 1991; Lee, 1991). Nevertheless, certain characteristics have been identified as common to the rural setting. Fitchen described three core components of rural environments in the United States: (1) a high quality of life in terms of non-material aspects; (2) sacrifices and difficulties that mean one has to live with fewer material items; and (3) a slower pace of life. Lee, in her review of definitions of rural life in the United States, noted differences in the parameters of population density, hospital size, and driving time to a hospital as they relate to urban, rural, and frontier settings. For example, she defined rural as a setting having more than 6 but fewer than 100 people per square mile and having a hospital of 25 to 100 beds within 30 minutes driving time. For Lee, the most remote setting, the frontier, has fewer than six people per square mile, a hospital with 25 beds or less or no hospital, and a driving time to a hospital of a minimum of 60 minutes.

Canadian definitions of rural also vary. Gillis and Perry (1991), in their study on physical activity and mid-life women, defined rural as an area with a population of less than 7500 people. Statistics Canada (1993) defined rural areas as places in which the population is less than 1000 people with less than 400 people per square kilometer. The Rural Committee of the Canadian Association of Emergency Physicians defined *rural remote* as rural communities that are 80 to 400 kilometers or one to four hours transport in good weather from a major regional hospital (Canadian Association of Emergency Physicians, Rural Committee, 1997). *Rural isolated* refers to communities that are more than 400 kilometers or four hours transport in good weather from a major regional hospital (Rennie, Baird-Crooks, Remus, & Engel, 2000). Using these definitions, northern BC encompasses urban, rural, remote, and isolated settings.

In spite of these different definitions, common elements of the overarching concept of rural have been articulated. Lee (1991) and Keating (1991) described three elements that are common to the concept of rural: occupational, ecological, and sociocultural. The occupational element refers to both farm and non-farm employment. Non-farm employment is a new and growing element in rural areas, which historically have been predominantly farm-oriented (Fitchen, 1991). In rural areas, work often assumes a primary role, with other activities such as health, education, and leisure activities assuming secondary importance (Dunkin, 1998). Ecological elements refer to population density and distance. Dunkin noted that although distance is a factor in the ability of rural residents to access health care services, difficulties are also encountered in rural areas due to rugged terrain, weather, and other transportation challenges. Those residents who depend on local health care services are therefore more likely to be indigent, aged, less mobile, or less affluent than those who are able to obtain services from more distant sources (Dunkin).

The third element of rural refers to sociocultural or rural ideology. Early immigrants to Canada's rural areas in harsh northern frontier environments developed certain values (Keating, 1991). These values persist today and include: being conservative in religion; right-wing in politics; supportive of the nuclear family; economically frugal; hard-working and individualistic yet interdependent with family, friends, and neighbors; having a spirit of self-determination and self-reliance; and a negative attitude toward receiving charity (Keating; Peters, 1995). American perspectives and definitions of health and health care in rural areas often describe health in terms of hardiness, independence, the ability to work, and reluctance to seek or accept help from outsiders (Bushy, 1990a; Long, 1993). In addition, in rural areas the need for health care services is mediated by family roles and responsibilities, the availability of a strong informal support system, level of trust in the provider, sensitivity to health problems, and the need for privacy (Dunkin, 1998). These three core elements of rural definitions - occupational, ecological, and sociocultural - have implications for women's health in geographically isolated environments.

Rural Perceptions of Health

Although most literature to date that addresses health and health perceptions has not addressed place of residence as a relevant variable, there is increasing evidence that place of residence and related environmental factors influence the way in which people think about health (Johnson, Ratner, & Bottorff, 1995; Long, 1993). Individuals who engage in particular behaviors or who avoid certain behaviors may do so because of contextual factors, regardless of their personal characteristics or predispositions (Johnson, Ratner, & Bottorff). At the outset it must be stated that no universal perception of health is held by those in rural areas (Long). However, some views about health are considerably more prevalent among rural dwellers than among urban dwellers. Key concepts regarding rural dwellers' perceptions of health and health care include work beliefs and health, health promotion beliefs and health, and isolation and distance.

Regarding work beliefs and health, Long and Weinert (1989) found in their research that rural dwellers tend to define health in terms of their ability to work. Rural dwellers may consider their health as good until their ability to work is compromised and until home remedies and neighborly advice fail. In subsequent research, Weinert and Long (1991) found that rural residents worry less about physical health and are more likely to reject the sick role than urban dwellers.

Contradictory evidence exists regarding rural dwellers' health promotion beliefs and behaviors. Nichols (1989) indicated that the health care orientation of rural residents may be present-time and crisis-oriented, suggesting that rural residents may hold minimal interest in health promotion beliefs and activities. However, a Canadian study (Johnson, Ratner, & Bottorff, 1995) noted that, compared to those living in large cities, rural residents engaged in healthier behaviors such as sleeping seven or more hours a day and eating three meals a day. Rural dwellers more than city dwellers also placed smoking cessation as a priority for health improvement. Therefore, contrary to Nichols' claim, some rural dwellers do take a future orientation toward health, indicating that they believe in and enact health promotion activities.

Regarding isolation and distance, rural residents may come to accept and adapt to these barriers to health (Long & Weinert, 1989). However, even with adaptive strategies, distance is a barrier that is difficult to overcome, especially if the rural resident is poor or requires frequent health care from distant health care professionals or institutions. Isolation and distance require that rural residents develop strong self-reliant attitudes and coping strategies (Bushy, 1998). Local and informal sources of health information may be valued over services provided by formal health care providers, and neighbors may be relied upon to provide physical, financial, emotional, and social support (Weinert & Long, 1991).

In their consideration of rural health literature, Long (1993) and Weinert and Burman (1994) build upon the above key concepts of rural health perceptions. Global rural-urban differences and rural regional and subcultural variations are important when considering the concept of health from a rural perspective. Rural-urban differences tend to be a matter of degree or emphasis, rather than actual difference (Long). For example, both rural and urban residents value health as the ability to work. However, Long discovered that urban dwellers more frequently and readily focus on the comfort, cosmetic, and life-prolonging aspects of health. In contrast, rural dwellers tend to perceive health needs primarily in relation to their ability to work. Rural dwellers place work needs before health needs, and have been found to tolerate pain for extended periods so that they are able to continue working (Long). Regarding regional variation, Weinert and Burman noted that understanding the health perceptions of rural residents requires careful consideration of marked variations within rural settings. Variation across rural regions can be based on age, gender, geographical location, income, race, ethnicity, occupation, and health status, as well as including variations related to belief systems and lifestyle. Such comprehensive understanding of variation is important for the development of timely and appropriate health care services and programs in rural areas.

In summary, rural perceptions of health, although varied, also subscribe to commonalities. Isolation and distance are common to rural dwellers, and rural residents tend to value health as the ability to work. However, various data exist about rural dwellers' beliefs regarding health promotion, and regional variation affects the diversity of rural dwellers' beliefs about health. Both the variations and commonalities are important to consider as they relate to the health perceptions of women in northern geographically isolated settings where rurality also exists.

Women's Health in Geographically Isolated Settings

In recent years federal and provincial governments and various women's groups in Canada have studied aspects of women's health. However, government and other research data regarding women's health in northern and rural settings are limited. Nevertheless, some characteristics of and implications for women's health in these settings can be drawn from studies regarding women in general. In this section, literature will be explored relating to *women's perceptions of health*, *priority areas of women's health in geographically isolated setting,* and *health needs of special groups of women*. Information from studies focusing specifically on women's health in isolated settings is included as it is available and relevant.

Kettel (1996) in her examination of global policies regarding women's health noted several factors about the interrelationships among women, health, and the environment that are relevant to the examination of women's health in the northern BC environment. Kettel noted that "women and men tend to occupy, use, and manage aspects of the biophysical environment in a gender-differentiated manner" (p. 1368). Women are the day-to-day health managers and care-takers. They are also the primary agents of disease control. For example, women use their knowledge about the biophysical environment to select and use various health care products and remedies to provide effective health care to themselves and their families (Kettel). As a result of this gender-differentiated experience, "gender may sometimes be as important, or even more important, a factor in exposure to a particular environmental illness than is residence in a particular country or neighborhood" (Kettel, p. 1369).

Kettel (1996) also stated that "the differential attention paid to men's environmental needs and interests...may, in fact, be as significant an environmental health hazard for women, as is poverty, illiteracy, and gender oppression" (p. 1376). As a northern resident, I have observed that northern BC communities tend to focus on the needs and interests of men, with less attention paid to the concerns of women. This differential, expressed in local newspapers, radio and television media and other communications, is linked to the male-oriented resource-based economies that form the economic foundation for northern BC families and communities. Therefore, because women inhabit different life spaces than men, and because men's life spaces in northern BC have received primary attention, it is important to understand women's perceptions and experiences of health in northern BC environments in order to effectively support health needs.

Women's Perceptions of Health

Canadian Women's Perceptions of Health

How Canadian women in isolated settings perceive health has not been the subject of extensive research. In 1997, Health Canada published on overview of women's health based on several papers that were prepared for Health Canada and for the Canada-USA Forum on Women's Health held in August 1996 (National Forum on Health, 1997). The overview highlights several important aspects of women's health in Canada, including the role of income and violence as factors influencing women's health, women's health service needs, and the needs of special populations, such as Aboriginal women and lone-parent mothers. However, women who live in geographically isolated settings were recognized in this overview in a very limited way;

their need for improved access to health care was the only specifically relevant issue noted. Moreover, the perspectives provided to Health Canada were predominantly those of ‘experts’, rather than of ordinary women themselves. Walters (1991, 1994), in her research and discussion of issues that have been neglected in research on women and health, noted that women’s health care priorities, when they have been determined, have sometimes differed from the priorities set by experts. Thus, Walters concluded that the voices of ordinary women need to be consulted and attended to in order to formulate policies and programs that effectively address women’s health issues.

Limited understanding exists about how women view health and their health issues. For example, answers to the following questions have yet to be discovered: How do women view health/illness? Do they rely on the medical model? To what extent do women follow their physician’s advice? Do women understand their illness/health in terms of the social and economic dimensions of their lives? (Walters, 1991, 1994). Various determinants of health have been associated with women’s health, but we have a limited understanding of how women themselves identify and make links among the determinants of health (Walters, 1991; Walters & Denton, 1997). In addition, we do not have good documentation of the social bases of women’s health nor a well developed theoretical framework (Walters, 1991; Walters, Lenton, & Mckeary, 1995). This study seeks to examine how ordinary women perceive health and how women maintain their health in a northern setting. Therefore, this study will help address some of the questions and gaps noted by Walters and others.

Canadian women’s perceptions of their health issues was the major focus of a study by Walters (1992). A sample consisting of 356 women in Hamilton, Ontario, were asked, “What do you think are the three most important health problems facing women in Canada?”, “What are the three most important health problems for you?”, and, “What do you think are the three most important social problems facing women in Canada?” The three most important problems facing women in Canada were identified as cancer, stress, and breast cancer. The three most important health problems for the women in the study were stress, arthritis, and being overweight. Mental health problems, back problems, headaches, and blood pressure were also concerns. The three most important social problems identified for women in Canada were violence against women, discrimination in the work force, and problems encountered by single mothers. Poverty followed closely as a fourth social problem. Walters noted that just over one fifth of the women were dissatisfied with the quality of medical care, often citing doctors' reluctance to acknowledge the problems the women faced. Although this study took place in an urban setting, it is one of few that was conducted in Canada.

Similar findings to those of Walters (1992) were obtained from Atlantic Canada where 458 women from across Nova Scotia were asked to list their three top health concerns for themselves and then for Canadian women (Davidson et al., 2001). The three main health concerns for Canadian women were: psychosocial issues, other specific illnesses such as diabetes and osteoporosis, and cancer. The three most important personal health concerns were: psychosocial issues, other specific illnesses, and heart and related diseases. These findings are particularly relevant to this study because the women in this study represented rural as well as urban locations and diverse ethnicities (Caucasian/European, Black, and Native/Aboriginal).

Another study explored women's health needs from the perspectives of health care providers and of women residing in communities throughout BC. This province-wide study was conducted by the British Columbia Women's Hospital and Health Center Society to identify the provincial role of this large Vancouver-based hospital (British Columbia Women's Hospital and Health Center Society, 1995). Six hundred women were involved in 71 discussion groups and 192 telephone interviews were held with a variety of service providers throughout the province. Results of this study revealed that women in BC had various health needs related to poverty, violence and abuse, social support, negative media depictions, an inaccessible and unresponsive health care system, limited access to and choice of health care providers, and a treatment oriented rather than a preventive and empowerment oriented health care system. The women in this study also recommended that additional women's health research be promoted. Although this study done by BC Women's Hospital highlights important health perceptions of women in BC, the particular perceptions of women who live in the northern part of the province were not clearly, consistently, or comprehensively identified. In addition, the strengths of northern women and the ways that they stay healthy in the face of northern challenges were not explored. Finally, the recommendations of the study focused on leadership, education, and other roles that a large, urban, southern based hospital can play in improving the health of women in BC. However, my study seeks to examine how northern women stay healthy and how women's health could be improved within the context of their own communities.

In another Canadian study, Young (1997) used a qualitative approach to explore farm women's perceptions of health and work. Young interviewed nineteen farm women in Alberta, asking them to describe their health and how farm work affects their health. The women in Young's study perceived health and being healthy as multidimensional, and as an interrelationship of mental, emotional, spiritual, and physical health. Central themes identified in the research were having a sense of balance, having a well rounded life, the importance of a positive mental attitude, and taking personal responsibility for health. Factors that affected the women's perceptions of health were identified as the fit of personal values with farming as a lifestyle, the woman's perceptions of her preparedness to do farm work, work activities, respect and recognition for contributions, assertiveness, exposure to work hazards, support from others, personality factors, attention to personal self and personal goals, and stressors of farm life. It will be useful to compare the findings of Young's study with the findings of this research, which included rural areas in a more northern location.

Women's Perceptions of Health Outside of Canada

Several studies have examined women's perceptions of health in non-Canadian settings. Weinert and Long (1991) noted in their research that US rural women highlighted adaptation and coping when defining health, while rural men focused on the ability to perform a work role. When comparing American rural and urban women, rural women tended to perceive more environmentally related stressors, whereas urban women perceived more financially related stress (Weinert & Burman , 1994). In addition, interpersonal dynamics were a greater source of stress for farm women than home and work roles (Weinert & Burman).

Woods et al. (1988) explored images of being healthy as described by 528 American women representing multiple ethnic groups residing in a large urban center in the Pacific Northwest. The women were asked in telephone interviews to respond to the question, “What does being healthy mean to you?” A content analysis of the data revealed 12 categories of positive health images including: lack of certain clinical manifestations, role performance abilities, adaptability, self-actualization activities, healthy life practices, positive self-concept, body image perspectives, social involvement, fitness, positive cognitive function, positive affect, and harmony. These images emphasized a eudaemonistic model of health, which connotes an exuberant sense of well-being (Smith, 1981). This finding is in contrast to Weinert and Long’s (1991) suggestion that rural women subscribe to an adaptation model when defining health. However, the study by Woods et al. supports the view that health is each person’s own experience of valuing that can be known only through a personal description. Although these studies and perspectives originate in the United States, they highlight aspects of health that may be useful to consider and compare to images and representations of being healthy that are depicted by women in northern BC.

In the United Kingdom, Calnan and Johnson (1985) explored the relationships between occupational social class and two dimensions of women’s health beliefs: concepts of health, and perception of vulnerability to disease. Sixty women in London (thirty women from a lower socioeconomic class and thirty women from a higher socioeconomic class) aged 21-55 years were interviewed regarding their health beliefs and vulnerability perceptions. Results revealed that a social class differentiation existed in relation to the way concepts of health were defined. For example, working class women more frequently used a uni-dimensional definition of health such as ‘getting through the day’ (a personal definition), whereas their professional counterparts more frequently used a multi-dimensional definition that included a wider range of elements such as being fit and active (an abstract definition). Regarding personal vulnerability to disease, professional women tended to feel more vulnerable than working class women. Professional women emphasized past or present experience with disease as the basis for their feelings of vulnerability, whereas behavioral explanations such as smoking behavior were used more frequently by working class women. The authors noted that fruitful areas of research could include exploring beliefs about control over health, beliefs about the value of health, and beliefs about the social costs and benefits of compliance with officially recommended health practices.

Women's perceptions of health in various locations in Canada and outside of Canada indicate that the concept of health is complex and multi-faceted, and that more information is needed about how context affects women's perceptions of health. In addition, the literature reviewed suggests that in addition to physical health, psychosocial health and factors that affect it are important to women. These studies helped inform my consideration of the perceptions of health expressed by the women in this study.

Priority Areas for Women's Health in Geographically Isolated Settings

High priority areas for women's health in geographically isolated settings will now be addressed as they are represented in the literature. These priority areas include *violence against women, economic insecurity and work-related issues, access to health services,* and *social support issues.*

Violence Against Women

Within both urban and rural populations, violence against women is an important health issue for Canadian women (Canadian Panel on Violence Against Women, 1993; Canadian Public Health Association, 1994; Canadian Advisory Council on the Status of Women, 1994, 1995; Harder, 1994; Walters, Lenton, & Mckeary, 1995; Women's Health Conference, 1993). One-quarter of all Canadian women have experienced violence at the hands of a current or past marital partner, and one-half of all women have experienced at least one incident of violence since the age of 16 (Canadian Panel on Violence Against Women). Among Aboriginal women, many of whom live in isolated settings, it is estimated that the rate of abuse may be as high as

80% (Canadian Public Health Association).

There are several factors in rural and northern areas that may contribute to increased violence and that complicate women's safe and appropriate resolution of violent situations. Isolation, male seasonal employment that may result in increased alcohol consumption and more abuse by the woman's male partner, the presence of hunting weapons, lack of affordable housing, lack of privacy and anonymity, attitudes that foster the belief that leaving one's partner necessitates leaving the town, fewer social and health supports, and harsher climates and geography - all of these factors inhibit rural and northern women's ability to effectively address existing or potentially abusive situations (Fishwick, 1993; Goeckermann, Hamberger, & Barber, 1994). Rural values such as those that define women's worth in terms of their responsibilities to home and family and that emphasize the primacy of the male perspective may also contribute to women staying in abusive relationships (White, Katz, & Scarborough, 1992). Although residents of rural areas in Canada express greater knowledge of violence than people living in urban areas (Kennedy, Forde, Smith, & Dutton, 1991), rural residents and communities may provide less than adequate support for women in these situations (Struthers, 1994).

Economic Insecurity and Work-Related Issues

By every measure, women are consistently more likely than men to experience poverty and economic insecurity (Doyal, 1995; Federal/Provincial/ Territorial Working Group on Women's Health, 1993; Nichols-Casebolt, Krysik, & Hermann-Currie, 1994). Women who face the greatest risk of poverty are single mothers, unattached elderly women, women with disabilities, and Aboriginal women (Canadian Advisory Council on the Status of Women, 1995). In rural and northern settings, where resources are limited, these women are particularly vulnerable.

Among industrialized countries, Canada is second only to Japan when it comes to the incidence of low-paid employment for women, and women are losing economic ground (Canadian Labor Congress, 1997). Canadian women in full-time jobs still earn only 71.8% of the income of their male counterparts, and women are concentrated in the lowest paying occupations (Canadian Advisory Council on the Status of Women, 1994). In the United States, the earnings of rural women are 50% below that of rural men, while the earnings of urban women are 34% below that of urban men (Bushy, 1993).

Income level has a direct impact on the health of women (Canadian Public Health Association, 1997; Reutter, Neufeld, & Harrison, 1995, 2000). Many poor single mothers become disadvantaged because of early pregnancy, the stresses of raising a child with few supports, and limited access to work opportunities. In addition, poverty affects prevention and treatment of illness (Canadian Public Health Association; Reutter, Neufeld, & Harrison, 1995). Women with low incomes engage in fewer preventive screening practices, such as mammograms and cervical screening for cancer, and, if they do contract breast cancer or cervical cancer, have a lower survival rate. Women who are poor are 1.6 times more likely to smoke than women with higher incomes (Jensen, 1994) and smoking has been linked to cervical cancer, menstrual disorders, early menopause, osteoporosis, and risks to pregnancy and fetal health (Canadian Public Health Association). In addition, poor women who seek help for mental health concerns are more likely to receive intrusive treatments, such as drugs, rather than psychotherapy, and they will therefore continue to live in stressful conditions, be reliant on medications, and have few supports (Canadian Public Health Association). These economic factors are important to consider in isolated northern communities, where employment and supports for low-income women are more limited.

Finding satisfying work that is respected and adequately compensated is compromised by several factors in northern settings. Gill (1984) and Luxton (1980 in their research in northern Canadian communities found that the traditional roles of women as wives and mothers are presupposed and desired in northern communities, and any other lifestyle for women is often ignored or discouraged. In addition, small communities have a limited selection of types and numbers of jobs, and women who are employed in these jobs may remain in them for a long time, partly because no other viable options exist. Part-time jobs in service and sales positions in restaurants, stores, and motels may exist, but these are insecure and very dependent on the economic health of the small community. Access to high paying positions in mining and forestry industries are largely denied to women (Wall, 1993). Thus, northern women may get jobs, but they are often not jobs that last, are respected, are adequately remunerated, or in which they can take pride (Heald, 1991).

The nature of women's work in rural settings has implications for women's health. Multiple role expectations and the subjugation of a woman's goals to those of the family business, such as a farm or ranch, affect emotional and physical well-being, as well as the woman's economic status (Bushy, 1990b). Women's work in rural areas is often considered to be voluntary, and not requiring financial reimbursement (Bushy, 1998). In Canada, women with advanced education often find it difficult to secure appropriate employment, or any employment at all, in small rural communities (Hunter & Whitson, 1991). In addition, women continue to do the bulk of household and child-care work, which is unpaid and often in addition to a full day's paid employment. In 1997, in Canada, the majority of married women employed full-time had all the responsibility for daily housework; only 10% of dual-earning couples shared responsibility for housework equally (Canadian Labor Congress, 1997). This relationship is likely to be at least the same or perhaps even less equitable for women in northern areas where traditional values regarding women's roles are more deeply entrenched.

Women in Canada are increasing their involvement in farm work, which exposes them to certain risks. In 1991, women represented 26% of all farm operators (Statistics Canada, 1995). These women are especially vulnerable to farm-related accidents and injuries, in part due to inadequate knowledge about farm machinery and livestock while trying to help with field work and chores (Wright, 1993). Due to economic constraints, farmers may use old or unsafe equipment, or equipment borrowed from a neighbor. The farm wife's unfamiliarity with this equipment may pose risks to her health (Wright). However, even new equipment which is designed and constructed with the male physique in mind may not be appropriate or safe for women. In addition, women are frequently responsible for caring for children and the home environment in addition to farm related chores, and these multiple tasks can increase women's risks of accident or injury (Wright). Women may also be at increased risk for cancers and other diseases and illnesses related to agricultural practices (McDuffie, 1994; Werner & Olson, 1993).

Access to Health Services

Access to a range of high quality appropriate health care services is another issue for women who live in isolated settings. A wide range of factors unique to rural areas limit access to care. Because of sparse populations and large geographical areas, health services either do not exist, are intermittent, or are limited in range and quality when compared to services in urban centers (Report of the Northern and Rural Health Task Force, 1995). For example, a woman who seeks help in addressing family violence may need to leave her community, including her job, friends, and social support network, because appropriate resources either do not exist in her community or are inadequate. Lack of transportation that facilitates access to resources is also an issue for women in rural areas (British Columbia Women's Hospital and Health Center Society, 1995).

Rural community values and dynamics affect access to confidential health services in small communities (Bushy, 1990b). In northern communities, reproductive care services for women are extremely limited or nonexistent. Even when services such as abortion and birth control services do exist, women are often discouraged from using them because of lack of confidentiality and influence from religious, patriarchal, and other community beliefs. In small northern communities, deviations from the dominant culture in terms of sexual orientation, culture, lifestyle, and economic status are more visible, and these deviations from the dominant culture can result in compromised access to health care (Anderson, Healy, Herringer, Isaac, & Perry, 2000; Morton & Loos, 1995; Report of the Northern and Rural Health Task Force, 1995).

Other barriers to health care access for northern women include weather and climate, which are especially problematic for women with disabilities and elderly women. Language barriers for immigrant women and the hearing or visually impaired may exist because small communities do not have the resources to assist in communication with these women (Leipert, 1999). Monopolies on health care by physicians, who are the de facto gatekeepers to health care in Canada, result in physician control of access to referrals and second opinions, type of care, and the number of female physicians (Rachlis & Kushner, 1994; 1998). Recent research that I completed in northern BC revealed that the number of female physicians in rural British Columbia is low, that they are often overworked, and that the values and priorities of male physicians can heavily influence and compromise the practice of female physicians and community health nurses in these areas (Leipert). Thus, because health care options are limited, and because of geography, weather, professional and community values, and the geographical location of services, northern women's health is compromised.

Social Support Issues

A supportive social environment has been identified as essential to women's emotional, social, cultural, spiritual, and physical well-being (Bushy, 1994; Phillips, 1995; Walters, Lenton, & Mckeary, 1995). Social support helps women to deal with problems such as smoking and alcohol and other substance abuse, and to meet exercise needs (Health and Welfare Canada, 1990). Social support may also be vital to a woman's ability to make transitions in her life, for example adjusting to a first child, returning to work (Harrison, Neufeld, & Kushner, 1995), or leaving an abusive relationship (Merritt-Gray & Wuest, 1995). On the other hand, a lack of social support and social isolation have been linked with poor health for women (Walters, Lenton, & Mckeary).

In rural and northern settings in Canada, social support is particularly important for women's health because of geographical and other forms of isolation (Luxton, 1980; Nadeau, 1982). In her research in northern Manitoba, Luxton found that, for northern women, social support can help raise awareness about the link between women's daily lives and the structures of industrial capitalism in single-industry towns. More specifically, social support can help women and others realize the fundamental role that women's work plays in resource-based communities. In addition, social support, by connecting women within their own communities, can counteract the influence of geographical isolation, encourage the sharing of common perceptions and experiences, and foster collective action to address issues and problems. However, the social support that women could offer to each other may be hindered in northern communities when women are discouraged by male partners from participating in gatherings away from their families and home responsibilities (Luxton).

Access to social support may also be compromised in northern geographically isolated settings because of challenging geography and climate, and a decreased range of social support options (Nadeau, 1982; Report of the Northern and Rural Health Task Force, 1995). In addition, women's juggling of multiple roles (employees, wives and mothers) further hinders the ability of women to access social support (Nadeau; Luxton, 1980). As a result, women in northern settings may be more socially isolated than women in other settings, and their health as well as the health of their families and communities may, as a consequence, be compromised.

Health Needs of Special Groups of Women

Over and above general health issues that affect all women in geographically isolated settings, certain subgroups of women are particularly vulnerable in these settings. In research done in BC, lesbian women identified fears of homophobia as the central issue in their decisions regarding health care (Anderson et al., 2000; British Columbia Women's Hospital and Health Center Society, 1995). The health of lesbian women in small rural communities in Canada may be compromised because most of the physicians in these communities are male (Peloso, 1996). Male physicians have been identified as having the most negative responses to women's declaration of lesbianism; other health care providers are seen as more supportive (Trippet & Bain, 1993). In addition, traditional attitudes about women's roles and threats to confidentiality in small communities may also contribute to poor health care for lesbian women (Anderson et al.).

The plight of disabled women has gradually gained attention in Canada. Priority issues for these women include discrimination which results in unemployment and other inequities, and transportation difficulties (Canadian Advisory Council on the Status of Women, 1994). These problems for disabled women can only be compounded in isolated rural and northern settings, which have fewer resources to dedicate to the special needs of these women.

Aboriginal women are another at-risk population of women. Aboriginal women, 32.8% of whom live in isolated settings, rank lowest of all people in Canada in terms of health and economic well-being (Canadian Advisory Council on the Status of Women, 1995; Provincial Health Officer's Annual Report, 1996; Report of the Northern and Rural Health Task Force, 1995; Statistics Canada, 1995). In 1990, 33% of Aboriginal women compared to 17% of non-Aboriginal women and 28% of Aboriginal men lived in a low-income situation (Statistics Canada). In 1991, 80% to 90% of Aboriginal female-led households existed below the poverty line (Browne & Fiske, 2001). In addition, Aboriginal women are faced with illiteracy; cultural isolation and discrimination; high incidence of tuberculosis, diabetes, respiratory diseases, and sexually transmitted diseases; high death rates from cancer of the cervix and cirrhosis of the liver; and a life expectancy of 7.4 years less than non-Aboriginal women (Browne & Fiske; Canadian Advisory Council on the Status of Women; Dion Stout, 1996; National Forum on Health, 1997; Report of the Northern and Rural Health Task Force). In spite of these evident needs, research reveals that health care services are either not available or not adequately used by Aboriginal women in Canada due to a lack of culturally appropriate care, prejudice, and care provided by male medical personnel (Browne & Fiske; Sokoloski, 1995).

Although the issues identified in this section do not include all of the health concerns of rural and northern women, they are the most commonly identified and discussed issues in recent studies and reports.

Summary

This review of the literature reveals that interest and knowledge about rural health and women's health in geographically isolated settings are growing. However, certain gaps remain. Few studies have examined women's health in isolated settings and, of these few, most of the focus has been on rural women's health. The health experiences of women who live in northern settings have received little attention. In addition, Canadian conceptualizations of women's health in geographically isolated settings are needed. Although there are conceptual similarities between geographical isolation in the United States and Canada, the cultural and economic histories and present contexts of the two countries are different.

This review has also revealed that most of the research and reports on women's health by governments and women's groups have used quantitative methodologies. Statistical and survey approaches may summarize some aspects of the health of some women in Canada. However, in-depth understanding of the health of women in isolated settings will be best achieved if both quantitative and qualitative methodologies are employed (Bushy, 2000).

Much of the literature does not sufficiently recognize or describe the importance of social, economic, and other non-physiological aspects of, and influences upon, women's health in isolated settings. Consequently, the meaning and effect of context on the health of women in northern BC remains largely unknown. The literature also insufficiently acknowledges or examines women's health sustaining capabilities and strengths.

In conclusion, there is a need for research that qualitatively examines women's perspectives on health in geographically isolated northern settings in Canada. The processes whereby women maintain their health in these settings also require explication. Such research would provide insight into the complex factors that affect women's health in northern settings, and the processes women use to maintain their health in the face of northern challenges and opportunities. By providing an opportunity for women to have a voice, this research and its findings have the potential to enhance quality of health in northern settings in British Columbia, and perhaps in other isolated settings in Canada.

In the next chapter, I describe the research method used to guide this study of how women maintain their health in a northern geographically isolated setting in Canada.

CHAPTER III

RESEARCH METHOD

In this chapter, I discuss the research method used in this study. The theoretical underpinnings of the feminist grounded theory method are discussed followed by ethical considerations, sampling, data collection, and data analysis. The chapter concludes with a description of strategies used to ensure rigor.

Theoretical Underpinnings of the Research Method

A feminist grounded theory method was selected for this study. This method is based on the tenets of *symbolic interactionism, grounded theory, and feminist inquiry.*

Symbolic Interactionism

The underpinnings of grounded theory methodology rest in symbolic interactionism (MacDonald, 2001b). Symbolic interactionism, one of the most enduring social theories of the twentieth century, originated in the work of George Herbert Mead in the 1920s and was further expanded by Herbert Blumer beginning in the 1930s (Chenitz & Swanson, 1986; MacDonald; Plummer, 1996). The researcher who engages in interactionist inquiry "needs to understand behavior as the participants understand it, learn about their world, learn their interpretation of self in the interaction and share their definitions" (Chenitz & Swanson, p. 7).

Within symbolic interactionist theory, four interweaving themes can be discerned (Plummer, 1996). The first theme suggests that human worlds are not only objective worlds but also immensely symbolic ones. Social life is expressed through symbols, and language is considered the most symbolic (Annells, 1996). A key concern for interactionists is the way humans assemble meanings - how humans define themselves, their bodies, emotions, behaviors, and acts; how they define situations they are in; and how they develop perspectives. In addition, interactionists realize that meaning is never fixed but is always emerging and changing, open to reappraisal and adjustment. A second theme relates to process, the belief that lives and situations are always evolving, emerging, and becoming. The third theme highlights the realization that the individual is not constructed in isolation; rather, the self is constructed through interaction with others. Interactionism, then, is concerned with how people come together in collective behaviors (Plummer). The fourth theme highlights symbolic interactionism's engagement with and focus on the real world, rather than abstract theory. Direct examination of the empirical world always forms the foundation of interactionist investigation (Plummer). These four themes merge together and form the core of interactionist inquiry.

Symbolic interactionist themes guided my study of the process of how women maintain their health in northern geographically isolated settings. The language and contexts of the participants assisted me in determining how the women defined themselves and their behaviors and perspectives, particularly as these related to health and to the northern contexts of their lives. By focusing on the real world, I was able to deal directly with what was actually happening, as well as with what the women thought ought to happen. In other words, I was able to "tell it like it is" (Glaser, 1978, p. 14).

Grounded Theory

Grounded theory is especially useful for identifying, describing, and illustrating knowledge in a field of inquiry about which little is known (Stern, 1980), as is the case in this study. Through the use of experiential data, grounded theory is well suited to identifying complex and hidden processes (Morse, 2001) such as those related to health. Grounded theory is a useful method for studying health because it helps discover and articulate health, influences on health, and health practices in a rich and dense way (MacDonald, 2001b, McMurray, 1994).

Grounded theory methodology has been primarily used, especially in nursing, for the purpose of micro level analyses (MacDonald, 2001b). Micro level analyses address the situated perspectives and interactions that shape the everyday lives of individuals. Grounded theory analyses have tended to focus on micro analyses of social and psychological processes rather than macro analyses of social structural processes (MacDonald). Grounded theory seeks to understand an issue or concern from the perspective of those affected by it. This tenet is also central to feminist approaches and to health promotion (MacDonald).

Recent discussions note that grounded theory can focus on both micro level and macro level analyses, and the conceptualization of complex interactions between and among these levels (MacDonald, 2001b). Macro level analyses recognize socio-ecological and other structural factors (economic, political, cultural, organizational) at community and societal levels that affect the health of communities and populations. Macro and micro realms are mutually interdependent and shape each other. Grounded theory, with its foundation in symbolic interactionism, recognizes the importance of processes of interaction and the way that individuals and collectives play a part in constructing social environments (MacDonald). Thus, grounded theory with its ability to analyze and conceptualize micro and macro realms is an appropriate research method to use in the articulation of knowledge regarding women's health.

Grounded theory is a research method that seeks to generate a theory that explains how the central problem in a study is resolved, solved, or processed (Glaser, 1978, Glaser & Strauss, 1967). Both inductive and deductive reasoning are used in grounded theory (Milliken & Schreiber, 2001). The grounded theorist begins inductively by gathering data and then posing hypotheses, which are confirmed or disconfirmed during subsequent data collection. Throughout data collection and analysis a researcher constantly asks, "What is this data a study of?", "What category or what property of what category does this incident indicate?", and "What accounts for most of the variation in processing the main problem that makes life viable in this situation?" (Glaser, 1992, p. 4). These questions help orient the researcher to what is actually happening in the participants' worlds, rather than to what the researcher expects or assumes is happening. Throughout the research, the researcher defers to the expertise of the participants to gain understanding of participants' realities, meanings, and behaviors (Milliken & Schreiber, 2001).

Constant comparative analysis technique forms the foundation for analysis and theory generation (Glaser, 1978, 1992). In constant comparative analysis, data are continuously analyzed and compared as they are generated. This type of comparison also forms the basis for decisions about theoretical sampling about if and where to seek further relevant data. Data collection continues until saturation occurs; that is, when additional data do not reveal anything substantially new or different about a category or the theory (Glaser, 1978; Schreiber, 2001).

Theoretical sensitivity forms the basis for grounded theory research (Glaser, 1978, 1992). Theoretical sensitivity "refers to a personal quality of the researcher...to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't" (Strauss & Corbin, 1990, pp. 41-42). Theoretical sensitivity combines the ability of the researcher to have insight into the research with the researcher's ability to interpret and "make something" of the insights (Glaser & Strauss, 1967, p. 46). A theoretically sensitive grounded theory researcher will be open and sensitive to the 'story' in the data as presented by study participants (Glaser, 1992), and is able to recognize what is important in the data and give it meaning (Morse & Field, 1995). The researcher must constantly seek patterns that indicate emerging concepts and their properties, and emerging theoretical relationships between the concepts. The theory derived by a grounded theory researcher emerges rather than being forced from the data (Glaser, 1992).

Theoretical sensitivity can be fostered by familiarity with extant knowledge. Glaser (1998) has stated that "the researcher should be reading vociferously...while doing grounded theory in order to keep up his theoretical sensitivity. It keeps the researcher super-sensitive to emergence [of concepts and linkages] without preconception" (p. 73 & 74). Familiarity with extant knowledge in various fields assists the researcher to "recognize remnants of other theorists' work, so that when glimpses of interesting leads are present in an interview, these leads may be pursued and verified, or recognized as new and unique phenomena" (Morse, 1994, p. 226). Reading literature in related and unrelated fields also helps expand one's ideas about the phenomena under study (Schreiber, 2001). Bias or forcing of concepts based on the literature is avoided by "bracketing" the literature and using it for contrast and comparison with emerging categories (Morse, 2001, p. 9). In other words, the literature simply becomes part of the data, along with interviews and other data sources. Maintaining a critical stance towards the literature and not privileging the literature but instead capitalizing on the insights it can provide assists the researcher to enhance the theoretical sensitivity that is vital to a grounded theory study.

Outcomes of the grounded theory method may vary and may contain interpretive and theorizing elements (Kearney, 2001). Interpretive outcomes focus on holistic portrayal and thick description without distillation to shared concepts and theory; theorizing outcomes focus on building and refining concepts and theories that integrate differences into an explanatory model. Boundaries between interpretive and theoretical outcomes are often blurred, and most research displays qualities of both types of outcomes (Kearney). The emphasis in this study is given to an interpretive-descriptive portrayal of outcomes and findings; this type of portrayal is important in an area where little is known. As this is a preliminary study in the area of northern women's health, more research is needed to build a more formal theory in which the identified concepts could be further refined.

Feminist Inquiry

Certain assumptions are made when engaging in feminist inquiry (Harding, 1987; Campbell & Bunting, 1991). These assumptions include: (a) the research is based on women's experiences and values women's perceptions as a valid way at getting at truth, (b) research is designed for women to answer questions that they want answered, and (c) the researcher is located in the same critical plane as the research participants (Harding). This latter assumption means in part that the researcher's point of view should be described and included as part of the data, and that participants should assist with interpretation and validation of data (Harding). My points of view were included in journal recordings and field notes which were considered part of the data, and participants were consulted to validate my analyses of their interviews—throughout the research process. Feminist methodology also assumes that knowledge must be elicited and analyzed so that women can use it to alter oppressive and exploitative societal conditions (Fonow & Cook, 1991).

While feminist research can be spoken of in a generic sense, it must be noted that there are various approaches that articulate what feminist research is and how it should be conducted. More specifically, three strands of feminist inquiry have been delineated: feminist empiricism, feminist standpoint theory, and feminist postmodernism (Harding, 1991; 1993). Feminist empiricism takes the view that reality is external to the knower and absolute, objective knowledge is possible, and that traditional science can reveal this knowledge. Standpoint theory subscribes to the view that humans influence reality and reality is not absolute, knowledge is intersubjectively and relationally created, and that research must start from women's lives using an array of research methods. Feminist postmodernism assumes that there is no single reality or ultimate truth, that the knower and the known are fused, that language is the basis of knowledge, and that science and power are intimately connected to determine what is taken as fact. In this study I have adopted aspects of both the standpoint and postmodern approaches. From a standpoint perspective, this study originates in women's lives where knowledge is relationally constructed by the women. The postmodern approach is reflected in the focus this study has taken on the language and the power of northern women, and in its attention to women's multiple realities.

Ultimately, feminist methodology seeks to remedy and prevent further bias against women. Because women experience bias personally and at the societal level, both a micro and a macro approach must be taken in research. Women's perspectives and experiences as well as the larger socio-political, economic, cultural and other societal structures must be addressed in research. Feminist inquiry is concerned with micro and macro issues, issues that include both the agency and structure of women's lives and experiences (MacDonald, 2001b; Wuest & Merritt-Gray, 2001). Not only are women's individual voices and experiences privileged in feminist research, but the larger social structures that influence women's lives are also considered.

Fonow and Cook (1991) have distilled four common themes of feminist epistemology and methodology. The first theme, reflexivity, is the practice of reflecting on and examining critically the research process and assumptions about gender. Reflexivity is needed because women and women's reality have not been adequately or appropriately acknowledged and included in research and knowledge development. Consciousness raising and collaboration between women and researchers are the purposes and focal points of reflexivity. Consciousness raising can occur with the study participants as well as the researcher as they come to more fully realize how structural inequities influence their lives. During research interviews, influences on the lives of the research participants were discussed. This process helped to raise my awareness and the awareness of the study participants regarding influences and inequities in our lives as women in the north. Some participants explicitly stated that, after the interviews, they thought more about their lives and the influences upon them, and about how these influences might be changed to improve their situation. I, too, became more aware of structural inequities in the north as a result of the research interviews. Such thinking indicates that consciousness raising has occurred.

The second theme, an action orientation, indicates the feminist orientation toward social change. Also known as praxis, this theme acknowledges the importance of the integration of women's knowledge and action to effect gender and societal emancipation. In this study, I asked women for recommendations of ways to improve women's health, thereby integrating their knowledge to effect improvements for northern women's health. I also intend to advance social change to improve the health of northern women by informing politicians and health care practitioners and policy makers about the results of this study.

The third theme, attention to the affective components of the research act, recognizes emotion as a source of insight. Also known as reciprocity or intersubjectivity, this theme connects the researcher and the research participant in the discovery of knowledge. The reciprocal nature of the research was evident in the comfortable and open interactions that prevailed in research interviews, and in the words of participants, such as those of Rhoda, who stated that she felt "partnered" with the researcher in the research. In addition, emotion was attended to during interviews and in analysis. For example, if women emphasized by tone of voice the importance of a perspective, I would ask them to elaborate.

The final theme is that the researcher uses the situation at hand as a valid source of knowledge. This theme acknowledges the value of women's lived experience and seeks to situate knowledge development in that experience. This study values women's experience of living in northern geographically isolated settings, and sought knowledge that was grounded in that experience.

In addition to these themes inherent in feminist research, Campbell and Bunting (1991) noted four dominant patterns in feminist writing. Feminist writing is important for feminist research because such writing explicates research findings in ways that are relevant and beneficial to women. The first pattern describes attention to unity and relatedness such that distinctions between work values and personal values or between theory and practice are minimized. My personal commitment to women's health was evident in research interactions and served to minimize distinctions between the work of doing research and my own personal values. Several research participants noted the presence of my sincerity and commitment, and commented that I "appeared interested", "you leaned forward", and "I feel much freer to tell you anything because I feel you are sincere". As a result of my unity of personal and work values, the writing of this dissertation is based on data that is more honest, open, and complete compared to data that could be obtained if the researcher did not attend to unity issues.

A second pattern in feminist writing is that of women's contextual orientation. Feminist thought is oriented to relationships between objects, ideas, and actions, and to holism rather than to division. My writing of the research findings in this dissertation reveals my attention to the research participants' orientation to their northern context and to holism in health. The third pattern acknowledges that women value lived experience, an intuitive sense of reality, and the subjective as legitimate ways of knowing. By including women's words and experiences in this dissertation, my writing explicitly acknowledges women's values of their lived experiences in the north, and the importance they placed on their subjective knowledge as a legitimate source of knowledge. In the fourth pattern, feminist thought is described as idealistic and optimistic, emphasizing development, growth, and change to embrace the cessation of exploitation. This feminist grounded theory study on how women perceive and maintain their health within geographical, social, economic, and other contexts in northern BC will provide information that can inform improvements to the health of northern women.

In conclusion, the assumptions, themes, and patterns that are the core essence of feminist inquiry and writing form the basis of the feminist inquiry in this study.

Feminist Inquiry and Grounded Theory

Certain congruencies and tensions exist between feminist inquiry and grounded theory. Wuest (1995) and Wuest and Merritt-Gray (2001) have explored congruencies and tensions between feminist theory and grounded theory. Congruencies include a recognition of multiple explanations of reality, a mutual focus on contextual influences, and a respect for theory as process. Additional congruencies include the mutual respect for contextual and relational forms of knowledge, and the acknowledgment that researcher bias influences research questions and analysis. In addition, feminist theory and grounded theory share the assumption that women can be knowers, and that their experience is a legitimate source of knowledge. Grounded theory, with its reflection of the symbolic interactionist tenet that respects persons' subjective interpretation of experience, supports the feminist tenet that women are experts about their experience and that subjective experience is valid data. In fact, Glaser (1978) has stated that the best way to approach a subject using a grounded theory approach is to say to the person 'teach me'. Such an approach is in keeping with a feminist methodology that respects women's knowing (Seibold, Richards, & Simon, 1994).

In addition to these congruencies, feminist research and grounded theory research hold some similarities in terms of their purposes and products. Rigor (1992) noted that feminist research should be *for* women, not *on* women. Although grounded theory does not take as its specific purpose research for women, it nevertheless can be employed in research that is for, rather than on, women (Wuest, 1995). In addition, feminist research seeks to produce emancipation and change (Acker, Barry, & Essevald, 1991). Grounded theory, by accounting for and interpreting substantive patterns of action that provide understanding, provides an access point for action and change. Grounded theory can, therefore, be a vehicle for emancipation and change (Glaser, 1992). In addition, Plummer notes that symbolic interactionism, the theoretical underpinning of grounded theory, these days "often provides a critical form of social analysis which aims...to improve the quality of everyday life for citizens...facilitate political action...[and] aid democratic activity" (p. 244). These wider emancipatory aims have placed symbolic interactionism "on the cutting edge of sociology" (Plummer, 1996, p. 238), and they have also found favor with feminist researchers who seek to examine and change the broad context in which issues of gender are played out (Plummer; Reinharz, 1992).

One area of tension between feminist theory and grounded theory centers on the potential imposition of feminist ideology on data analysis (Wuest, 1995). Some feminist researchers have recommended that researcher interpretation of the data should take primacy over participant interpretation on the basis of participants' 'false consciousness'. This recommendation is based on the belief that participants may identify with patriarchal interests rather than with female interests and, therefore, not be able to effectively interpret data (Wuest). However, in grounded theory, a feminist researcher is compelled to build theory from the participants' perspectives, even if participants may not subscribe to feminist ideologies. This tension may be addressed by recognizing that ideologies, such as feminist ideologies, are used by the grounded theory researcher to "form guidelines and reference points" for question formulation (Glaser, 1978, p. 39). For example, in this study, feminist ideas were incorporated into such questions as: "How does being a woman in this community affect your health?" "How would you change your community to be more supportive of women's health?" and "Why do these issues exist in your community?" The theoretical perspective of the researcher is used to "uncover data that might otherwise be overlooked" (Glaser, p. 39).

Wuest (1995) advised that the key to ensuring that the assumptions of both feminist theory and grounded theory are respected lies in the use of reflexivity. Reflexivity means "to reflect upon, to examine critically and explore analytically the nature of the research process" (Fonow & Cook, 1991, p. 2). In this research, while collecting and analyzing data, I promoted a reflexive approach by asking questions such as "How is this woman like me? How is she not like me? How are these similarities and differences being played out in our interaction? How is that interaction affecting the course of the research?" (Hall & Stevens, 1991, p. 21). I also pondered broader questions such as, "Why are things the way they are for this woman, this community?" "What institutions and societal structures are influencing what is happening here?" In addition, I promoted reflexivity throughout the research by making extensive journal recordings and field notes. Documentation of my thoughts, feelings, questions, and analyses in this way facilitated research that respected both feminist and grounded theory approaches.

Several researchers have combined the grounded theory method with a feminist approach to research (Merritt-Gray & Wuest, 1995; Reinharz, 1992; Seibold, Richards, & Simon, 1994; Wuest, 1997a, 1997b). Grounded theory, with its attention to theory derived from the data, fits well with a feminist approach that values the voices and perspectives of women. In addition, feminist grounded theory, by including theoretical sensitivity and theoretical sampling, allows for the inclusion of participants not usually included in research, such as women in isolated northern settings, in knowledge development (Wuest, 1997b). Theoretical sensitivity, theoretical sampling, and the use of a reflexive approach support a grounded theory method that is consistent with feminist principles of being useful to participants, avoiding oppression, and reflecting on both intellectual traditions and the research process (Acker, Barry, & Essevald, 1991). As a result, in feminist grounded theory research, study participants are more likely to be treated respectfully as research partners, and to have their perspectives and concerns heard and reflected. Indeed, several participants in this study commented that they felt respected and heard.

In summary, this research seeks to identify a process women use to maintain their health within the geographical, social, and economic contexts of northern BC. Because micro and macro realms that consider agency and structure must be taken into account if progress is to be made in improving the health of women (MacDonald, 2001a, 2001b, 2002; Walters, 1992; Walters, Lenton, & Mckeary, 1995), a feminist grounded theory approach is an effective method for this research.

Ethical Considerations

Prior to beginning data collection, I attended to ethical considerations. Moral responsibility begins when the study begins and continues to the end of the use of data obtained in the study (Archbold, 1986). Field workers in qualitative research studies must exercise common sense and moral responsibility to participants, the study, and to themselves (Fontana & Frey, 1994). Ethical principles for research in northern Canada have been produced and recently revised (Association of Canadian Universities for Northern Studies, 1998) (Appendix B). These principles and other ethical considerations regarding this feminist grounded theory study have been addressed in the following ways.

Prior to the commencement of the study, I obtained letters of permission from the University of Alberta Health Research Ethics Board and from the University of Northern British Columbia Ethics Review Board (Appendix C). Prior to each initial interview, information about the study was mailed to each participant (Appendix D). At the first interview, I reviewed this information with each participant to ensure that her decision to participate was voluntary and informed. I also informed each participant that she had the right to withhold information, to request that information not be used or be erased from the tape, and to end her participation at any time with no repercussions. Participants were invited to ask questions or raise concerns about the study throughout the research process. Prior to the first interviews, each participant also signed a consent form (Appendix E) and was provided with a copy of the consent form for her own records. However, consent was viewed as an ongoing decision in this study, and each participant was asked after each of the first interviews if she remained willing to consent to the use of the interview data. This approach to consent respects the sometimes serendipitous and unpredictable nature of the unfolding of interviews (Seibold et al., 1994). It is also a way to show respect and equalize power between the researcher and the participant (Cotterill, 1992). Those participants who lived in contexts of particular significance to the purposes of the research, such as in particularly remote locations, also signed a consent form permitting the taking of photographs by the researcher (Appendix F).

Participants had the option of requesting a copy of their transcripts to review, revise, and keep. Three participants requested a copy of their first interviews. Two participants made revisions to their transcripts to clarify data and to omit data that they felt might identify them. Only one participant requested a copy of her second interview transcript. Providing transcripts to research participants and inviting their commentary shows respect and equalizes power between the researcher and the participant.

Issues of confidentiality and anonymity were addressed as follows. Pseudonyms selected by participants were used instead of actual names to identify tapes and transcripts. Tapes, transcripts, and research notes were kept in a secure location separate from consent forms and coded data; this information will be kept for seven years after the research is completed. Consent forms were kept in a secure location and will be maintained for a minimum of five years following completion of the study. Each interview was conducted in a private area and at a time mutually agreed upon by the participant and the researcher. If data are used for future studies, I will seek appropriate ethical approval before using the data. Publication and presentation of the research will be done in a manner that protects the identities of participants.

The reflective and personal nature of this research raises the possibility of positive and negative consequences for participants. Most participants found the sharing of their perspectives and experiences to be empowering and helpful. However, one participant found that sharing certain personal experiences caused discomfort and unease, distressing her to the point of crying. As a researcher, it was my responsibility to assist the participant to find the help she desired. In this particular instance, turning off the tape recorder for a few minutes and talking with the participant was adequate for her needs.

Sampling

Sampling in grounded theory studies includes purposive and theoretical sampling (Glaser, 1978; 1992). The initial sample is a purposive sample of participants who are experienced in the phenomenon of interest and can speak to this phenomenon. Theoretical sampling is based on the need to collect data to examine and develop categories as they emerge from analysis of the data (Glaser, 1978).

The number of participants is not determined at the outset of a grounded theory study. Rather, sample size is determined by the adequacy of the data as data are analyzed and theory emerges. Only as the researcher "discovers codes and tries to saturate them by looking for comparison groups, does both what codes and their properties and where to collect data on them emerge. It is never clear cut for what and to where discovery will lead" (Glaser, 1978, p. 37). However, the recommended sample size for a grounded theory study is approximately 30 to 50 interview instances (Morse, 1994). In this study, 25 women formed the study sample. I interviewed each of the women a minimum of two times, for a total of 50 interview instances.

Women in the study met the following inclusion criteria: (a) they had lived a minimum of two years in either of two of the northern British Columbia health unit areas, specifically the Cariboo and Northern Interior Health units (In Appendix A, identified as Health Units 15 and 18). These health units were selected because they are diverse yet representative of the north in that remote, rural, and urban areas are present; (b) they were 20 years of age or older; (c) they were able to understand, speak, read, and write English; and (d) they were able and willing to reflect upon and articulate their experiences. These criteria were set for the study sample for several reasons. Women who have lived at least two years in northern BC are likely to have sufficient northern experience to speak to the study's area of interest. Women of the specified ages are likely to be able to provide rich and varied perspectives on the lives of adult women across a range of ages. The perspectives of women who have varied backgrounds and experiences will assist in the development of a dense and meaningful theory. Regarding the other sampling criteria, it is important that the women be able to understand and participate in English so that they can effectively assist with the provision of data and its verification. Similarly, the ability of the participants to reflect upon their experiences assists in the provision of data that richly and effectively represents their experiences.

Recruitment of the initial sample was approached in a variety of ways. An invitation to participate in the study was published in local newspapers in various northern BC communities in the Northern Interior and Cariboo Health Regions (Appendix G).This invitation briefly outlined the purpose of the study and invited women to write or telephone (collect) the researcher if they were interested in participating or wanted further information. In addition, I posted a recruitment advertisement on cable television channels that serve the Northern Interior and Cariboo Health Regions. Recruitment posters were also posted in various key locations throughout the Northern Interior and Cariboo Health Regions. Some of these locations included women's centers, women's clothing shops, hotel check-in areas, livestock tack and feed stores, a livestock auction market, general stores in small towns, public health offices in small communities, and at the university in Prince George where I work. I was also interviewed by various local media about my research. The university interviewed me for a regularly scheduled television program that highlights the endeavors of the university. A journalist of a local radio phone-in program interviewed me on a live broadcast about my research (see Appendix G). The exposure of my research through the public media was useful, with the radio event being particularly useful as the program is aired across the north and, therefore, effectively advanced my invitation to women who lived in particularly remote circumstances.

As a result of these recruitment endeavors, I received an overwhelming response from women in northern BC. Over 100 women telephoned, emailed, or dropped by my office to volunteer to be part of the study. Indeed, some women *demanded* to have their perspectives included in this research. I developed a form

(Appendix H) that I completed for each of the women who contacted me. This form documented information which helped me to purposively sample women so as to obtain diversity in the sample and theoretically sample.

Sampling for study participants can cease when saturation of categories occurs, that is when additional data does not reveal anything substantially new or different about a category (Glaser, 1978). Although very little new information was obtained after interviewing 15 participants, to ensure a rich data base that included maximum diversity of perspectives and experiences, I included several more women in the study. (This was facilitated by the overwhelming response I received to the study). The inclusion of these additional participants increased the depth and scope of the data and contributed to the validity and reliability of the findings. In particular, the additional perspectives helped to ensure that the categories, their properties, and the theory were based on the greatest degree of depth and scope. Furthermore, these additional perspectives confirmed that the data were, indeed, saturated, that is that no new concepts, categories, or properties could be discerned.

Data Collection

The grounded theory method supports a variety of data generation approaches including interviews, participant observation, and review of written documents (Glaser & Strauss, 1967). Observational data were collected as I traveled to interviews throughout the north, and in the interview locations themselves. Observational data included information about geographical terrain, climate, distance, road conditions, farms, ranches, towns, and homes. In addition, I collected written documents and media information regarding the north. Examples of this information include maps of northern BC, travel brochures and tourist guides, and locally produced histories, newspapers, and pamphlets about the communities. I also considered the works of a noted northern poet (Baldwin, 1997) and works of a historical nature (Lewis, 1998; MacEwan, 1975; Rasmussen, Rasmussen, Savage, & Wheeler, 1976). These sources of information provided rich descriptive data that helped me deepen my understanding of the historical, social, cultural, geographical and other contexts in which northern women live. In addition, this information presented data about how northern communities perceived themselves and wished to be perceived by others. Observation, document, and media information were incorporated into my analysis and are reflected in the findings of the study.

The primary method of generating data in this study was by semi-structured and open-ended interactive interviews with individual women. All of these interviews were audio-taped. The audiotapes were transcribed and the transcriptions were analyzed using the NVIVO computer program for data management. I personally conducted all of the research interviews. This process promoted familiarity and trust between the participants and myself, and, as several of the participants remarked, it fostered honest and open interaction which, in turn, helped ensure the validity of the research findings. In addition, direct contact with participants raised my awareness of the influences of context and of the meaning and significance of nonverbal communication, which enriched my findings.

As a feminist researcher, I was particularly sensitive to issues of power, control, and vulnerability in interview situations (Devault, 1990; Ribbens, 1989). I attempted to establish rapport that fostered feelings of reciprocity, caring, and a 'friendly stranger' approach (Cotterill, 1992). I also listened "around and beyond words" (Devault, p. 101) for difficulties of expression such as the use of 'crutch words' (such as 'you know') and for what was left unsaid. This depth of listening is particularly important in feminist research because one of the purposes of such research is to recover and examine unnoticed and excluded experiences of women (Devault). Several women in the study remarked on the fact that this was the first time that they had been consulted about health issues, and they valued the research for its valuing and inclusion of their perspectives. I found that the feminist grounded theory method was congruent with my public health nursing practice skills, developed over a period of some seventeen years of practice as a public health nurse. These skills include competency in communication, the ability to establish trusting relationships, and the ability to engage women in discussions of mutual importance, such as women's health issues. Several women in the study stated that I put them at ease and helped them communicate openly and honestly about sensitive issues.

Interview Process and Protocol

Because of the overwhelming response I received to my recruitment initiatives, I was able to select women from diverse situations who met the inclusion criteria of the study. To this group of women I mailed information about the study (Appendix D). Within two weeks of this mailing, I contacted each of these women to answer any additional questions and arrange details of the interview time and place. The participants and I considered distances, travel time requirements, weather, and road conditions when making these interview arrangements. As a result, I completed all first interviews during the spring, summer, and fall months of 1999, when travel to distant northern locales was more manageable. In total, I have traveled over 1,800 kilometers to interview the participants in my study. Travel was by automobile over highways and country roads and trails, and by boat across a mighty northern river, the Fraser.

Interviews were arranged at mutually convenient times and places. For the first interviews, the women were interviewed in their homes, at their work places, or in my hotel room. For second interviews, they were interviewed in the same locations or at the university. Due to weather, distance, and time constraints, some second interviews were conducted by telephone. Interviews were conducted during evenings, week days, and weekends, in order to accommodate the women's schedules as well as my own. Each participant was interviewed twice for a total of 50 interviews. In addition, each woman was telephoned a third time for her response to the summary of my analysis of her second interview. These third contacts were not audio-taped; however, I did take notes to incorporate as part of the data of the study.

At the first interview, an Informed Consent form was discussed and signed by each participant (Appendix E). At the conclusion of the first interview, selected personal and health information was requested of the participant (Appendix I). This information assisted me in understanding the health and context of each woman as well as of the sample of women as a collective entity. This information was also valuable for data analysis and theory generation, by providing additional data about the lives and experiences of the participants.

First interviews with the participants lasted from one and a half to four hours. At the beginning of these interviews, I engaged in mutual friendly dialogue to establish rapport and create a research relationship that was sensitive to issues of power, control, and vulnerability. In addition, I was aware that participants may be interested in certain aspects of my own life and health experiences. Accordingly, as appropriate, I shared aspects of my own life with participants. One aspect that several participants were interested in was my own experience with living in geographically isolated settings. Sharing my life experiences of growing up on a Saskatchewan grain farm, working as a public health nurse in rural settings, and living in northern BC fostered research relationships by implying some commonalities of experience and background between myself and the participants. In addition, sharing personal data demonstrated respect and understanding for the sharing and experiences of participants.

The formal part of the first interviews used open ended questions (Appendix J) as beginning points of discussion and dialogue. Responses were used as 'jumping off' points to guide subsequent discussion to meet the purposes of the research. Verbal probe questions were used in such a way as to elicit information that seemed important to the participant or to me. In these ways, data were sought that were varied, dense, and rich in terms of amount, type, and depth. Such data fostered the generation of a theory that is itself rich, dense, and meaningful (Strauss & Corbin, 1990).

At the end of each interview, after the tape recorder had been turned off, each participant had the opportunity to debrief about the interview and the data shared. Some women used this time to share particularly sensitive information that they did not wish tape recorded, for example, their experiences with abuse or with particularly volatile situations. I have respected their wishes not to include this information in the research data. However, this confidential information did provide a greater depth of understanding about women's lives and the contexts in which they live. Following the interviews, in some cases, I took photographs of participants, their homes and environments. Photographs were taken to provide pictorial representations of women's lives in northern settings that could be used in the dissemination of the research findings. At the end of the interview, to promote participant control over data, each participant was again asked if she agreed to permit her interview data to be used in the study. All participants agreed. Participants were also asked to select a pseudonym that would be used in dissemination of the research to protect their identities. All references to participant names in this document refer to the pseudonym selected by that participant.

Immediately after each interview, I recorded field notes and made journal recordings to capture unrecorded nonverbal and verbal information and impressions. I recorded field notes on a form I created for field recording in this study (Appendix K). Field notes recorded data about the location of the interview, the people present, the environment, nonverbal behavior, interview content, significant quotes, researcher's impressions, analysis ideas, issues for further exploration in subsequent interviews, and methodological decisions (Miles & Huberman, 1994; Morse & Field, 1995). Field notes documenting researcher decisions and changes regarding methodology provide an audit trail to enhance reliability of the study (Morse and Field). In addition, data from the field notes added to the analysis of interview situations, thereby enlarging, enriching and conveying additional credibility to the emerging theory (Glaser & Strauss, 1967).

In addition, throughout data collection and analysis, I recorded in a journal my personal impressions, biases, feelings, and reactions to participant settings, and to the research experience itself. This journaling experience assisted me to reflect upon the research in a way that was separate from the data collection experience itself. It also increased self-awareness and assisted me in dealing with effects, such as stress, potentiated by the research experience and data (Lipson, 1991). Data from the journal and the field notes were reviewed and considered as part of the data that informed the theory generated from the research. These notes and recordings were considered prior to subsequent interviews with each participant to determine areas for further elaboration or clarification. In addition, the notes and recordings facilitated data analysis by highlighting ideas that may have been forgotten or neglected by the researcher over time.

After each initial interview was coded using NVIVO, I created a written summary of my understanding and analysis of that interview. This summary was then sent to the participant and formed the initial point of discussion in the second interview. Second interviews were scheduled with participants after all of the first interviews had been completed and coded. In second interviews, I asked each participant to respond to the summary for accuracy and completeness. I also asked for responses to the summary in terms of content, and if participants had further information to add to first interview data. In addition, I requested participant responses to emerging categories and theory. These responses served to further develop and validate the theory. For example, as the concept of hardiness emerged from the data, I asked women in subsequent interviews whether they thought hardiness was important for northern women and, if so, how it was developed and enacted. I also asked participants in second interviews for information regarding the research method used, such as the importance of meeting me in face-to-face interviews, and for participants' suggestions regarding dissemination of the research findings and areas for future research.

Following the second interviews, I again summarized my analysis of each interview and sent this information to each participant. I then telephoned each participant for her perspectives regarding the summary and for any final comments she might wish to make about women's health in northern BC. I was able to contact 24 of the 25 participants for their responses. (Lillian, the 86 year old women in my study, had died five days after our second interview). The majority of participants stated that the summaries for both interviews were remarkably accurate and insightful. Participants also stated that the summaries gave them a view of themselves from the outside, from the researcher's stance apart from their worlds, and that this view was useful in helping them to think more critically and deeply about their health and the health of other northern women.

In addition to the interviews, several of the women in the study provided additional unsolicited information. Vicki contacted me by email to inform me of a recent publication that addresses northern BC health issues. Prior to her first interview, Margaret, a 69 year old woman who had made a successful recovery from a stroke, wrote for this research a summary of her life and her experiences with recovery from stroke. This information was valuable in enriching my understanding of ways women return to health and maintain health following a life-threatening condition in northern communities. After her first interview, Casey, a 37 year old woman who lives on a ranch but who grew up in a large urban center, faxed to me a two page document in which she described ways women can stay safe in isolated northern environments. This information was very valuable in understanding some of the environmental safety issues for women in northern settings, such as threats from wild life and being alone for long periods. Casey also suggested ways that women can stay healthy and safe in rural northern environments. Rosie, a 59 year old nurse who lives in a very remote community, took me on a tour of her small community following her first interview, pointing out historical landmarks and providing detailed information about residents and life in that community. This tour and time devoted to the interview resulted in my spending over four hours with Rosie in her home and community, talking and observing. In addition, Rosie's husband, who asked to be present during the first interview, added information about the northern context ~~in~~ general and their community in particular, and encouraged his wife to elaborate on her experiences and perspectives. Thus, in these ways I achieved a more in-depth understanding of life in northern communities.

In addition, several participants provided information I requested as a result of the information they had shared during interviews. Robin, a 59 year old woman who lives on a farm close to a small community, mailed me information about the history and characteristics of her small community. Rosie, a 59 year old nurse who lives in a very remote setting, mailed me a copy of a paper she had written for a course she studied for her degree in nursing, in which she addresses substance abuse issues in northern BC. Rosie also compiled and sent a list summarizing medical equipment and drugs she presently stocks to treat illnesses and injuries of community members, and a second list summarizing equipment, medication, and other items that she would like to have available.

The unsolicited data as well as the data provided over and above the interviews provide valuable information about how women stay healthy and promote the health of others in northern locations. This additional information highlights the knowledge, abilities, and self-sufficient attitudes of women in maintaining their health in northern isolated setting. In addition, these data indicate the level of interest and commitment of the women in the study. These data were included in the analysis and theory building activities of this study.

Data collection concluded when I mailed a summary of the findings, which included a description of the emerging theory, to all participants. I invited participants to write or telephone me collect if they had comments about the summary. One participant contacted me, and I selectively contacted five participants who I expected would still be interested in and able to comment on the findings. The responses of these participants revealed that the findings were acceptable. Indeed, several of these participants remarked upon the comprehensiveness and accuracy of the findings. The responses of these participants were recorded as field notes and included in the study as data and validation of the emerging theory.

Analysis

Analysis was guided by the tenets of the grounded theory method, particularly the tenets proposed by Glaser (1978, 1992). Analysis began with the first interview and continued throughout the study. I reviewed each of the 50 interview transcripts while listening to the audio taped recording of the interview. While reviewing the transcript, I documented my preliminary analytical ideas on the transcript and added nonverbal and other data which the transcriber of the tape may have omitted or not understood. As a result, the transcriptions of the interviews were as complete as possible and contained initial analysis thoughts. These more complete transcripts with their preliminary analytical ideas were then imported into the NVIVO program and formed the basis of further analysis. This further analysis involved the procedures of *open coding, selective coding, theoretical coding,* and *memoing.*

Open Coding

Analysis proceeded with open coding (Glaser, 1978, 1992). The purpose of open coding is "to generate an emergent set of categories and their properties which fit, work and are relevant for integrating into a theory" (Glaser, 1978, p. 56). Transcripts were examined line by line, constantly coding for categories and properties of categories. Line-by-line coding deters the researcher from imposing extant theory or her own beliefs on the data, thus focusing attention on research participants' views and realities (Charmaz, 2000). Because of the multidimensional nature of the data, I would often attach several code labels to the same segment of data. For example, a participant's transcript may be addressing topics related to access, distance, and quality of care, all in the very same sentence. I constantly compared open codes with data and codes from other interviews with the same participant, as well as with interview data from other participants. This constant comparison process helps establish and underline uniformity in the data and the varying conditions of that uniformity, generates new properties of concepts and more hypotheses about what is happening in the data, and establishes the best selection and fit of concepts and hypotheses about concepts to generate a theory that fits, works, and is relevant (Glaser, 1978).

As coding proceeded, codes were clustered together into categories that were more refined and abstract. These categories "conceptualize the empirical substance of the area of research" (Glaser, 1978, p. 55). These more abstract codes help to move the theory to a more generalizable understanding and application, and help to connect the theory to extant knowledge (Morse, 2001). Codes can be classified in two ways (Glaser): codes that arise from participants' own words, known as *in vivo* codes, for example, "redneck" and "hardy"; and implied codes such as "attitude" and "philosophy" or codes derived directly from data in the study, for example "education" and "spirituality". As *in vivo* codes become subsumed into higher levels of abstraction, "the language may change to reflect the researcher's evolving interpretation of the participants' experience" (Milliken & Schreiber, 2001, p. 186). For example, women's comments about familiarity, sense of community, lack of resources, and outsider status were eventually subsumed into the more abstract codes of Positive Elements and Negative Elements of the Sociocultural Environment. Abstract codes represent a particular strength of grounded theory in that participants' perspectives as well as the disciplinary and reflective knowledge of the researcher and the literature relevant to the field of inquiry can all be included in the categories and patterns that grounded theory identifies (Morse, 2001).

As directed by the grounded theory method (Glaser, 1978), throughout the analysis, I asked certain neutral questions of the data. First, I asked "What is this data a study of?" This question allowed for complete emergence of codes and categories from the data, while continually alerting me to the fact that what I originally thought I was studying might not be the case. For example, I did not expect access to health care to be as pronounced and multi-faceted a health problem for the women in my study as it has turned out to be. Second, I asked "What category or what property of what category does this incident indicate?" This question kept me from getting lost in the data and required that I look for codes that relate to each other. Third, I asked "What is the basic social psychological problem faced by study participants and what process processes the main problem?" These questions helped me keep the substantive directions of my study in focus and enabled me to identify the main problem faced by study participants - vulnerability to health risks, and the process participants use to address this central problem - developing resilience.

Selective Coding

Selective coding delimits and reduces the work of open coding by focusing coding on the emerging core problem and process (Glaser, 1978; Stern, 1980). Selective coding in this study can be articulated using the example of the emergence of the core process of 'developing resilience'. At the beginning of data collection and coding, because of its importance to several of the research participants, 'developing self-reliance' began to emerge as a significant process. Thus, I began to consider 'developing self-reliance' as a potential core process. However, with further data collection and analysis, it was revealed that the concept of self-reliance was not sufficiently broad to capture other aspects (such as helping others and being politically active) of how northern women maintain their health. Upon further data collection, analysis, and discussion with senior researchers, it seemed that the concept of 'adapting' could more ably capture the core process of how northern women maintain their health. Adapting seemed to reflect strategies related to making the best of the north, such as taking a positive attitude and developing fortitude. However, with further data collection and analysis, reading, and discussion, I became aware that 'adapting' did not fully capture the scope and depth of the perspectives and actions of study participants. Adapting seemed to imply adjusting to what is; northern women were also using strategies that helped to move beyond what is to what could be. For example, the political action initiatives and the strategy of women leaving the north seemed to go beyond the concept of adapting. Thus, I considered other concepts that would more broadly and appropriately capture northern women's strategies of maintaining their health. Ultimately, the core process of 'developing resilience' seemed to best capture the scope and depth of the strategies northern women use to maintain their health.

Developing resilience emerged as the core process because it incorporated several of the criteria for generating core categories (Glaser, 1978). The core process of developing resilience seemed to be central, and to account for much of the variation in participant perspectives and behaviors. For example, women in the study did not simply adapt to what is, they also engaged in actions that would improve their situations. In addition, strategies relevant to developing resilience, such as becoming hardy and making decisions about health care services, seemed to reoccur frequently in the data, and to have increasingly clear and grabbing implications and relationships to other categories and their properties.

Thus, I began to focus coding on these and other emerging categories that related to the core process of developing resilience. In addition, my memo writing (described below) became more focused and I started to integrate data as well as identify gaps for further theoretical sampling. I also began to look for conditions and consequences that related to the core process of developing resilience. For example, I began to question in memos and in my journal whether women in circumstances not yet sampled in the study would experience similar or different issues regarding resilience. I began to ask, "How do other women in other situations in northern BC experience resilience?" "How is developing resilience different and the same for women of varying backgrounds and experiences?" Questions such as these guided my theoretical sampling so that I was sensitized to the importance of selecting women of diverse backgrounds and experiences as study participants. Thus, selective coding helped me create a relevant and rich theory that is based on appropriately selected data.

Theoretical Coding

Theoretical coding identifies properties and dimensions of concepts, codes, and categories, and conceptualizes "how substantive codes relate to one another" (Glaser, 1978, p. 55).

An example of theoretical coding is offered in the following description. As categories emerged in this study, it became evident that certain codes related more clearly to the category of limited access to health related and other resources than to other categories such as isolation or being silenced. I therefore began to determine the number and nature of the categories and codes. As I reviewed data in the codes and categories, their properties and dimensions became clearer. For example, the category of limited options was revealed to have several dimensions such as goods, services, and education. In addition, it became evident that some categories, such as taking a positive attitude and seeking social support, were, in fact, the properties or dimensions of higher level, more abstract concepts such as Becoming Hardy and Making the Best of the North respectively. In turn, some of these more abstract concepts seemed to relate to even more abstract concepts. For example, the isolation, limited options, limited power and silencing that the women described seemed to be aspects of the more abstract concept of Marginalization. Similarly, the risks to women's physical and psychosocial health and risks of inadequate health care seemed to be dimensions of the more abstract concept of Vulnerability. Accordingly, some categories were collapsed under or combined with more abstract concepts.

During the process of thinking about and determining abstract concepts such as Marginalization, Vulnerability, and Resilience, I was aware of debates in the literature about advantages and disadvantages of selecting pre-existing concepts. One advantage of abstracting to pre-existing concepts is that emerging knowledge can be linked with extant knowledge on that topic, thus extending knowledge development, establishing theoretical cohesion among studies, and enhancing theoretical richness (Morse, 2001). In addition, reflecting on other theoretical developments assists the researcher to compare findings with other knowledge as a springboard into the analytic process (Morse), and helps to focus the inquiry and give it boundaries for comparisons in facilitating the development of theoretical outcomes (Morse, 1994). Furthermore, comparing findings to other study findings helps a researcher new to grounded theory in developing confidence in analysis rather than becoming mired in data (Morse, 2001). One disadvantage of using pre-existing concepts in the development of a grounded theory is that people may bring to the work their own understandings of these concepts, thus clouding the meaning of the concepts as articulated in the study. In addition, by choosing concepts that already exist, the researcher may be tempted to force research data and analyses to fit these concepts (Glaser, 1998).

These disadvantages can be minimized using several strategies. The researcher must realize that concepts that already exist provide perspective without permitting them to dominate data collection and analysis (Morse, 1994). Throughout the study, I attempted to ensure that the data drove the theorizing and abstraction of the analysis, and that knowledge about concepts provided perspective but did not dominate or unduly influence data collection and analysis. The labels of marginalization, vulnerability, and resilience ascribed to concepts in this study emerged from the research data, and were identified after preliminary analysis was completed. As I read and thought about concepts, I constantly asked myself about the relevance of the view that pre-existing concepts were bringing to the research data. For example, in thinking about the concept of adapting, I realized that the research data revealed ideas, such as moving beyond what is, which were not reflected in 'adapting'. Thus, the pre-existing concept of adapting did not fit with the data, and was consequently rejected as the core process in the study.

Another strategy to counteract disadvantages of using pre-existing concepts is that research analyses and other information must be constantly verified and cross-checked to determine accurate interpretation (Morse, 1994). In this study, I verified analyses with each participant after each interview and at the end of the study. After the analysis of each interview, I provided a written summary of my analysis to each participant. I then asked each participant in a subsequent interview about the accuracy of my analysis as articulated in the summary. In addition, at the end of the study, I provided to each participant an extensive written summary of the analysis and study findings, including descriptions of concepts and their linkages. All participants were invited to contact me to discuss this summary. In addition, I contacted several participants who I thought would still be interested and available to comment on the accuracy of the findings as presented in the written summary. In these ways, I attempted to ensure the accuracy of my analysis, as articulated in the concepts and their theoretical linkages, with study participants. In addition, throughout the study I discussed analyses and emerging concepts and theoretical linkages with more senior researchers. Using these strategies, the concepts of Marginalization, Vulnerability, and Resilience were seen to emerge from the data, rather than being used as *a priori* categories to drive data collection and analysis.

Analysis then proceeded by focusing on interrelationships among the higher level, more abstract substantive code categories, such as Marginalization, Vulnerability, and Resilience. This analysis was guided by a theoretical pattern that was emerging from the data (Glaser, 1978). As this pattern emerged, and as substantive code categories became more abstract, I began to pose questions about relationships (Corbin, 1986). For example, I asked, "What is the relationship between marginalization and vulnerability?" "What is the relationship of vulnerability to resilience?" "What is the relationship of the northern context to marginalization, vulnerability, and resilience?" I inquired about possible linkages related to antecedents and conditions that influence these concepts and the consequences of these concepts. For example, I asked how marginalizing conditions related to vulnerability and to resilience, and what were the consequences of northern women's resilience.

Accordingly, I returned to the data I had already collected and asked more pointed questions, and I returned to the field and asked similarly pointed questions of participants. For example, I inquired of the data and of the women more specifically about aspects of marginalization and vulnerability and how they dealt with aspects of marginalization and vulnerability in their environments. I also theoretically sampled to determine perspectives of women with other backgrounds and characteristics. In these ways, I sought to clarify and dimensionalize emerging categories and their relationships.

Data saturation of the categories occurred when further data collection did not reveal any new information relevant to the emerging categories and their theoretical relationships. In other words, new information obtained did not provide further insight into categories or their relationships, and the categories and the theory seemed to be elaborated in complexity (Creswell, 1998). I knew that I was obtaining data saturation when I began to hear similar comments about variables, categories, and relationships. For example, similar information about isolation and limited access to health care resources was remarked upon by all of the women in the study. This information revealed repetition in the information and confirmation of previously collected data. Thus, data saturation was indicated, with little new data forthcoming from subsequent interviews (Morse, 1994).

Visual representations, or diagrams, of one's analytic scheme are useful as analysis proceeds and in representing the completed theory (Corbin, 1986; Morse & Field, 1995). After analysis of the first set of interviews was completed, I diagramed some of the substantive codes and their relationships. This diagraming process helped me to organize data and illustrated how codes might link together (Corbin). In addition, the diagrams highlighted areas where the theory needed further development, for example in extending the dimensions of the categories of marginalization and vulnerability. The diagrams grew in depth and integration as analysis proceeded and the theory was developed.

Memoing

Throughout the analysis process, the researcher documents ideas, insights, thoughts, and feelings about the emerging theory in the form of memos (Glaser, 1978). These memos assist in analysis by: (a) helping the researcher obtain insight into tacit, guiding assumptions; (b) increasing conceptual depth by encouraging the researcher to look for themes and patterns; (c) capturing speculations about properties, relationships, and theoretical sampling; (d) capturing ideas for future consideration; and (e) noting thoughts about the relationship of the emerging theory to established theories and concepts (Morse & Field, 1995). Memos are considered part of the data and are included in analysis and theory generation (Glaser).

I began memoing at the same time as I began coding the data. Memos were inserted within the NVIVO program at relevant points in interview transcript data. I also hand wrote memos as part of my field notes and journal entries. My memoing documented insights into assumptions in several ways. For example, as interviewing proceeded, I began to question in my memos my assumption that the isolation experienced by women in northern environments was predominantly a negative influence on their health. Accordingly, I was alerted to data that noted the positive effects of living in isolated environments. In memoing, I documented themes and patterns, such as data relevant to the emerging categories of marginalization and vulnerability. I also memoed my speculations about properties, relationships, and sampling when I considered the need to extend sampling to include women with more diverse characteristics, such as women of various ages and cultural backgrounds. My memos also contain ideas for future research and suggestions for ways to disseminate the findings of the study. In addition, I discussed in memos some relationships of the emerging theory to established theories and concepts. For example, my memos discussed benefits and limits for a woman from outside the community, an 'outsider', who has married a member of a community, an 'insider'. The insider/outsider concept is an established concept (Lee, 1998b; Long & Weinert, 1989), which data from this study extends and elaborates upon.

Memoing thus assisted me in capturing emerging ideas and analysis, determining theoretical sampling directions, defining code and category boundaries, outlining conditions under which codes emerged or were evident, dimensionalizing categories, and developing theoretical connections among concepts. By using memoing extensively, I was able to describe properties of codes and categories, determine data saturation, and ascertain the core category and subsequent theory of the study.

At the completion of the study, each participant will receive a copy of the executive summary of the study and its findings. This summary will be provided as a way to demonstrate respect for and appreciation of the time, efforts, and perspectives shared by the study participants. All of the participants stated in second interviews that they were looking forward to receiving this summary; several participants stated that they would also be interested in reading the dissertation in its entirety. A copy of the dissertation will be placed in the library of the University of Northern British Columbia to facilitate its access by women and others in the north.

Strategies to Ensure Rigor

I used several strategies to ensure the scientific rigor of this feminist grounded theory project. Throughout the study, I adhered to strategies and recommendations set out by both the grounded theory method (Glaser, 1978, 1992) and feminist research approaches (Hall & Stevens, 1991). I chose strategies to ensure rigor that are proposed by Glaser because I predominantly used a Glaserian methodology in this research. I used the feminist strategies proposed by Hall and Stevens because they are comprehensive and detailed, and would thus ensure that the research was adequately reliable and valid.

Grounded Theory Strategies

Glaser (1978, 1992) holds that grounded theory studies must meet four criteria in order to ensure good scholarship and good analysis: the theory must *fit, work, be relevant,* and *be modifiable.* First, the theory generated must *fit* the data such that "its categories and their properties will fit the realities under study in the eyes of subjects, practitioners, and researchers in the area" (Glaser, 1992, p. 15). Fit was confirmed in this study in several ways. During analysis, I ensured that categories were generated directly from the data. I used line by line coding, and I used participants' own words to name some of the codes in order to ensure that the findings accurately reflected the realities of the participants. The findings were confirmed by study participants after each interview and at the end of the study. Several participants stated that they were amazed at how accurately my summaries of their interviews reflected their perspectives. I have made presentations of my research to other women in the north, female colleagues, and female researchers; responses to these presentations have revealed strong endorsement of the fit of the findings with their realities.

A second criterion of rigor for grounded theory studies is that the theory generated should *work*, that is it should explain the major variations in behavior with respect to the processing of main concerns of the participants (Glaser, 1992). A theory that works will "explain what happened, predict what will happen and interpret what is happening" (Glaser, 1978, p. 4). In addition, a theory that works will "get the facts" (Glaser, 1978, p. 4) of what is going on in the research, and "be relevant to the action of the area" (p. 5).

I sought to achieve a theory that works in several ways. First, I met with women in their home communities so that I could understand the context and action of their lives. This helped me develop a theory that is relevant to the lives of the study participants. Second, I developed rapport and trust with participants to facilitate comprehensive and open disclosure of data. Some of the women stated that they had revealed information to me that they had only told their physician and perhaps a close friend. Thus, my establishment of rapport helped me 'get the facts' of what was happening. Third, during interviews I sought to achieve a depth of understanding of the scope of each woman's perspectives. For example, I would state, "Please tell me more" or "Can you elaborate on that?" I would also ask women for their interpretations of experiences: "What meaning does that have for you?" or "Why is that important?" These questions helped me get the facts and achieve a relevant theory. Fourth, I constantly revised and developed hypotheses to account for all known cases in the study. I scrutinized data not only for similarities and congruence, but also for negative cases where divergence and variation existed. For example, for one participant with multiple sclerosis, mental and spiritual health were not as important as physical health. This finding did not fit with the holistic view of health expressed by many of the other women in the study, even the women who were physically unwell. Further data collection revealed reasons why this participant valued physical health. Fifth, I sought to create a theory that works by reviewing relevant literature and presenting aspects of the theory at regional and national conferences that addressed the health of women in geographically isolated settings. In these ways, I was able to obtain input from others who live in northern settings or who work in this area of inquiry. In addition, I discussed my findings and the emerging theory with colleagues at the university and with students in nursing theory courses and women and health courses that I taught. In these ways, I sought to create a theory that explains major variations and actions and that gets the facts, in essence, a theory that works.

If a theory fits and works, it meets the third criterion of rigor, *relevance* (Glaser, 1992). Relevance is achieved when core problems and processes are allowed to emerge from the data (Glaser). As I have explained, the theory emerged from the data, and has been determined to fit and work by the study participants, other women who live in northern BC, and by other researchers in the area. Therefore, the theory meets the criterion of relevance.

The fourth criterion of rigor in grounded theory research is that the theory must be *modifiable*, which means that it must be readily able to accommodate the integration of new concepts and data (Glaser, 1992). In keeping with recommendations by Glaser

(1978) for ways to achieve modifiability, I tried to avoid "doctrinairism and excess loyalty to pet ideas" (Glaser, 1978, p. 5), and I attempted to keep an open mind to new and emerging concepts as I collected and analyzed data. For example, I formulated open-ended research questions to initiate data collection that would privilege research participants' perspectives. During data collection, I also reiterated open-ended questions until participants had no further reply. During analysis, I discussed with participants and my research committee emerging ideas and concepts and I read widely to gain perspectives on concepts and linkages that were or could be emerging from the data. During the whole research process, I took special note of any data that contradicted or challenged my initial ideas and I incorporated this data into my thinking and theorizing. In these ways, I attempted to achieve a theory that was modifiable and open to new concepts and ideas.

In conclusion, in these ways, I attempted to achieve scientific rigor by formulating a grounded theory that would fit, work, be relevant, and modifiable.

Feminist Research Strategies

The scientific rigor of this study was also attended to using criteria proposed by Hall and Stevens (1991). Strategies for scientific rigor adopted in feminist research ensure that research processes and outcomes are well grounded, cogent, justifiable, relevant, and meaningful, and, therefore, reliably and validly adequate (Hall & Stevens).

The first of the ten criteria proposed by Hall and Stevens (1991) is that of *reflexivity*, the continuous reflection on research processes. Reflexivity assists the researcher to foster integrative thinking, make values explicit, and consider the relative nature of knowledge. To promote a reflexive approach, I focused on the researcher-participant relationship and asked questions such as "How is this woman like me? How is she not like me? How are these similarities and differences being played out in our interaction? How is that interaction affecting the course of the research...illuminating and/or obscuring the research problem?" (Hall & Stevens, 1991, p. 21). In addition, I promoted reflexivity by journaling and in my considerations of the research process as it unfolded. These reflexive activities helped me think about the similar and diverse situations of the women in the study, compared to my own situation. For example, some women in the study were older and some were younger than me, some women had different perspectives regarding health and living in the north than I did, and some women lived in different socioeconomic situations than mine. By reflecting on the similarity and diversity of the women and their experiences compared with my own situation, I was able to foster integrative thinking of diversity and similarity, become aware of my own values and make them explicit, and consider the relative nature of knowledge.

Credibility, the second criterion, ensures that the research report "presents such faithful interpretations of participants' experiences that they are able to recognize them as their own" (Hall & Stevens, 1991, p. 21). Throughout the study, I sought confirmation from research participants to ensure that interpretations were credible. To foster credible disclosure, I was sensitive to factors that may adversely or positively influence participants' responses, such as social relations, power dynamics, motives, and cultural differences. I addressed these factors in several ways, such as by wearing casual clothing and adopting a relaxed manner to promote psychological comfort when interviewing participants, and by reflecting back to participants their language to ensure adequate understanding and to return the power and control of their words to them. Credibility was also attempted by asking each participant to review written summaries of each of her interviews, as well as the final more general summary that included the emerging theory.

Rapport, the third criterion, is engagement in the research relationship between the researcher and participants such that the researcher is able to "achieve the depth and scope of data collection and analysis required to present a credible description of women's experiences" (Hall & Stevens, 1991, p. 22). Elements of rapport include trust in relationship, length and frequency of contact, intimacy of setting, depth and specificity of information shared, verbal and nonverbal indications of comfort and openness, participants' willingness to be involved over a period of time, and their inclination to recruit other participants, if required (Hall & Stevens). These elements are important to consider in studies such as this, which essentially depend upon the self-reporting of participants. All of the women in this study expressed trust and comfort in the research relationship. I was able to spend lengthy periods of time, a minimum of one and a half hours and frequently longer, with each participant in each of the first face-to-face interviews, and all participants made themselves available for second interviews. Several of the second interviews were as lengthy or longer than the first interviews, which indicates participants' comfort in the research relationship. In addition, several of the participants invited me into their homes for research interviews. Several of the women were very committed to my understanding of their experiences. Rosie, a woman who lives in a very remote area, asked her husband to meet me at the river crossing to ferry me to her home across a major river. In addition, Rosie was very open during the interview and she offered to give me a tour of her community in her truck following the interview. Another participant asked if she could dine with me following our interview, and two other participants stated that the research relationship seemed like a "partnership", and that I seemed like a person the participant would like as "a friend". During the interviews, women shared very personal and sensitive information, sometimes for the first time, and sometimes for the first time outside of their doctors' offices. Additionally, several of the women demonstrated commitment to this study by offering to recruit neighbors and friends to participate in the study. Thus, I feel that I have been able to establish good rapport with study participants.

Coherence is a fourth way to assess adequacy and ensure rigor. Research findings are coherent if they are well founded in and consistent with the data, systematically connected in a logical discourse, and if they faithfully represent the stories and behaviors participants communicate (Hall & Stevens, 1991). The tenets and processes of grounded theory methodology are especially useful in achieving the criterion of coherence (Wuest & Merritt-Gray, 2001). The findings of this study emerged from the data and attempted to faithfully represent the stories and behaviors of each participant. Confirmation of the findings by the participants following interviews and during analysis further affirm that the findings represent their realities.

In the fifth criterion, *complexity*, explication of the complexity of women's lives is sought by "locating the analysis in the context of participants' everyday lives, exploring the influences of larger social, political, and economic structures, and providing historical background" (Hall & Stevens, 1991, p. 23). I sought to obtain contextual data and achieve the explication of larger social and historical structures and backgrounds by interviewing each woman face-to-face in her community, and by consulting professional and non-professional literature, such as relevant published research and local community newspapers. I was also able to review several community documents that presented historical data about the communities where some of the study participants lived. In addition, using theoretical sampling advanced by the grounded theory method, I facilitated achievement of the complexity criterion by including in the study women from diverse as well as similar backgrounds and locations.

Consensus, the sixth criterion, is represented by congruence among "behavioral, verbal, and affective elements of particular observations, verbal responses, and written records" (Hall & Stevens, 1991, p. 24). A commitment to consensus honors the plurality and diversity of women's experiences, thus enhancing the complexity of the research. Consensus ensures that data have greater accuracy, and that conclusions can be stronger. In this study, I attended to the consensus criterion in several ways. To determine consensus and congruence among behavioral, verbal, and affective elements of observations, verbal responses, and written records, prior to formal analysis of each interview I reviewed my post-interview field notes and I read each transcript while listening to the audiotape of the interview. In this way, I was able to check for and include elements of behavioral, affective, and observational data congruence between transcripts and my observations. In addition, information obtained from multiple data sources enabled me to be confident that diverse views were considered and that there was no contradiction in their meaning.

Understanding the consensus of a study is also fostered by the inclusion of negative cases or experiences in the study (Hall & Stevens, 1991). When comparing accounts, the researcher is advised to consider social positions, environmental contexts, and experiential backgrounds in order to gain a perspective on the similarities and differences of participant viewpoints (Hall & Stevens). By theoretically sampling for women with diverse experiences, ages, social positions, and environmental contexts, I sought to determine the nature and boundaries of data consensus. Consensus would have been strengthened if I could have included other women in the study, such as women from additional social positions such as homeless women, prostitutes, lawyers, and physicians, lesbian women, and women from other cultural backgrounds who live in northern BC.

Feminist research also addresses issues of *relevance*, the seventh criterion. The relevance of the research can be judged by "whether the questions address women's concerns and by whether the answers to these questions can serve women's interests and improve the conditions of women's lives" (Hall & Stevens, 1991, p. 25). In this research, the open-ended nature of the interviews allowed women to express concerns that were most relevant to them. Furthermore, in research interviews, I specifically asked participants for their perspectives about what would improve their health and the health of other northern women. Consequently, this research is relevant in that it addressed women's concerns in ways that served women's interests, and it sought to improve women's lives. In addition, theory generated from this research should be relevant to the development of local, regional, and provincial health programs and policies that improve northern women's lives.

The relevance of this research is also verified by the overwhelming response to my recruitment endeavors. Indeed, women continued to volunteer to be part of the study up to six months after recruitment ended. One woman who was not included in the study telephoned me a year after recruitment had ended to ask about the study findings and to offer to assist me in data analysis. Many of the women who were included in this study commented that they felt that they were heard and taken seriously. The participants also had hopes that the research would help to improve the health of women in northern BC.

The eighth criterion addresses issues of *honesty and mutuality* (Stevens & Hall, 1991). Information about the research purposes and design must be provided to participants in ways that are understandable and relevant. Prior to the first interviews, I sent information about the study to each woman. At the beginning of the first interview session, I reviewed this information with each woman and thoroughly answered any questions she raised. I was receptive to any questions or concerns about the study throughout the research process. For example, several women wanted to know what my background was and where I was geographically located. The fact that I had lived in rural and northern locations, and that I was located in their northern region seemed to enhance the mutuality that the participants and I were able to establish.

Honesty and mutuality were also fostered by offering the women a copy of their interview transcripts. Three women requested the transcripts of their first interviews. One of these women is a writer and she wanted her transcript to “see her words on the page”. The other two women were concerned that they had revealed information in their interviews that could compromise their anonymity. I sent each of these women a copy of her first interview transcript, and I invited the women to omit any information from the transcript with which they felt uncomfortable. I informed them that I would not use their omitted information in the research. Each of these women did omit certain identifying information and they provided these changes to me. When I asked these women if they would like the transcripts of their second interviews, the writer said she would like a copy, but the other two women stated that they felt comfortable with my ability to protect their identity in the research, and, thus, they did not desire copies of their second interview transcripts. In addition, several women remarked at the end of the research that they felt that they could be honest with me because I was honest with them. These incidents reveal that the women sensed honesty and mutuality in the research.

In addition, a feminist research relationship must attempt to develop honest and mutual research relationships that reduce power inequalities and that facilitate respect and cooperation (Reinharz, 1992; Stevens & Hall, 1991). This type of relationship was particularly important for women in this research because they had frequently experienced disrespect for and denigration of their perspectives in other situations, such as in interviews with physicians. A research relationship that is based on honesty and mutuality can be established by the sincere interest the researcher shows in each participant's experiences, and by the respect that is conveyed to participants for their sharing of time, efforts, and information (Hall & Stevens). I treated every participant with dignity, as a person deserving of equal care and respect. I demonstrated respect and facilitated cooperation by arranging interviews at times and locations that fit with the women's needs, by providing a copy of the findings to each participant at the conclusion of the study, and by explicitly expressing my thanks to participants for participating in the study. In addition, my keen personal and professional interest and experiences and my respect for women's concerns helped me to establish collaborative relationships based on honesty, respect, and mutuality. Lilac, a 72 year old research participant, explained how cooperation and respect were fostered in the interviews:

> " [it's] just a relationship of respect...Like, I felt very awkward, very - I'm not worldly wise and you...asked the leading questions and so for me, all of a sudden, I'm babbling along...so I feel much freer to tell you anything because I feel you are sincere in what you're doing...".

These comments suggest that participants were at ease, and felt respected.

Naming, the ninth criterion, is "learning to see beyond and behind what one has been socialized to believe is there" (Hall & Stevens, 1991, p. 26). Naming is addressing women's lives on their own terms and generating concepts using words that directly express women's experiences. Naming is powerful in two ways (Hall & Stevens): it defines the value of what is named by the emphasis of selecting it, and it denies reality to what is not named. In addition, naming helps recover and examine unnoticed and excluded experiences of women (Devault, 1990). Ways to remain sensitive to naming in research include trying to understand the gendered reality of women's lives, using women's language to create theory, and by presenting women's stories and voices to illustrate analytic arguments (Hall & Stevens). A feminist study is adequate if the voices of women participants are heard in the research account. Several women in the study remarked that part of the reason this research was important was because their voices were heard in the research, an occasion which they felt rarely occurred. The words, stories, and perspectives of the women in this study formed the very basis of this grounded theory research. Their words and perspectives are clearly represented in the analysis of the research as evidenced in the coded documents. In addition, women's words and perspectives are highlighted in accounts of the research, such as in this dissertation and in presentations I have given about the research.

Relationality, the final criterion of rigor in feminist research, refers to the positive value of collaborative working relationships with participants and collaborating scholars (Hall & Stevens, 1991). I strove to establish collaborative relationships with participants throughout the research process by being attentive to participants' needs regarding the times and locations of interviews, consulting participants throughout the analysis process, and by attending to issues of power and control in interviews. Comments by participants indicate that I was able to establish collaborative relationships with them. For example, Rhoda stated:

> Actually there would be no changes [to the research relationship]. You've got humor, you're warm, you make eye contact, you're attentive, you don't interrupt. We can sit together very close without feeling threatened or overwhelmed or overbearing. You're sensitive, kind, and caring, and what can you change about that?

I also sought to develop collaborative relationships with researchers in my field of inquiry, my dissertation committee. As well, I have discussed my analysis and findings with other researchers in the area of women's health.

These ten criteria for adequate feminist research as well as the four criteria for good scholarship and analysis in grounded theory research formed the basis for the establishment of rigor in this research.

Summary

In this chapter, I have discussed the research method used in this study. The theoretical underpinnings of the feminist grounded theory method were elaborated. Ethical considerations, sampling, data collection, and data analysis techniques were then discussed. This was followed by a description of strategies used to ensure rigor. In the next chapter, I begin the discussion of the study findings.

CHAPTER IV

FINDINGS: THE SAMPLE, THE THEORY, AND THE NORTHERN CONTEXT

In this chapter I discuss findings related to the study sample, the theory (briefly described), and the northern British Columbia context.

The Sample

Twenty-five women comprise the study sample. These women represent diverse characteristics. Eleven of the women reside in the Northern Interior Health Unit area and 14 in the Cariboo Health Unit (Appendix L). Within these Health Units, the women live in various types of geographical locations including cities, towns, in a community with under 20 residents, and on ranches and farms. Cities vary in size from 85,000 residents in Prince George, the largest city in northern BC, to smaller cities, towns, and hamlets. Some of these communities are several kilometers apart, while others are hundreds of kilometers from any major center. The women have lived in northern settings from three to 72 years. Most of the women have lived in northern BC or other remote or rural locations all or most of their lives; other women have substantial non-northern experience with which to compare their present life in northern BC. Culturally, one woman is Metis, one woman is First Nations, two women are of Asian background, three women are of European background (one Swiss, one British, and one Irish), and the remaining 18 participants claim Canadian Caucasian backgrounds.

Other demographic characteristics of the sample are depicted in Table 1 on the next page. During the time period of the research, the women varied in age from 21 to 86 years: two women were in their 20s, five women were in their 30s, six women were in their 40s, seven women were in their 50s, two women were in their 60s, two women were in their 70s, and one woman was in her 80s. The women had various educational backgrounds. Only two women had less than Grade 9, while most women (15) had completed post-secondary education. The marital status of the women in this study was also varied, with over half (14) being married or living common law, five divorced or separated, two widowed, and four never married.

Table 1

Sociodemographic Information About Study Participants

Characteristic	Number of Participants
Age	
20-30	2
31-40	5
41-50	6
51-60	7
61-70	2
71-80	2
81-90	1
Education	
< Grade 9	2
Grade 9-13	8
Trade/Technical Diploma	8
University Undergraduate Degree	6
University Graduate Degree	1
Marital Status	
Married or Common Law	14
Divorced/Separated	5
Widowed	2
Never Married	4
Employment	
Currently Employed	
Full Time	10
Part Time	7
Not Employed Outside the Home	3
Retired	5
Rating of Health	
Good	16
Fair	8
Poor	1
Annual Household Income	
<$10,000	2
$11,000-20,000	6
$21,000-30,000	1
$31,000-40,000	5
$41,000-50,000	2
$51,000-60,000	4
$61,000-70,000	1
$71,000-80,000	2
>$80,000	2

Regarding employment, 10 women worked full time, seven worked part time, three were not employed outside the home, and five were retired. Economic circumstances varied. Eight women had annual incomes below $21,000, six between $21,000 and $40,000, six between $41,000 and $60,000, and five over $60,000. Sixteen women rated their health as good, eight as fair, and one as poor. Health problems identified included mental health conditions, such as depression and bipolar disorders, and physical health conditions, such as cancer, multiple sclerosis, and fibromyalgia.

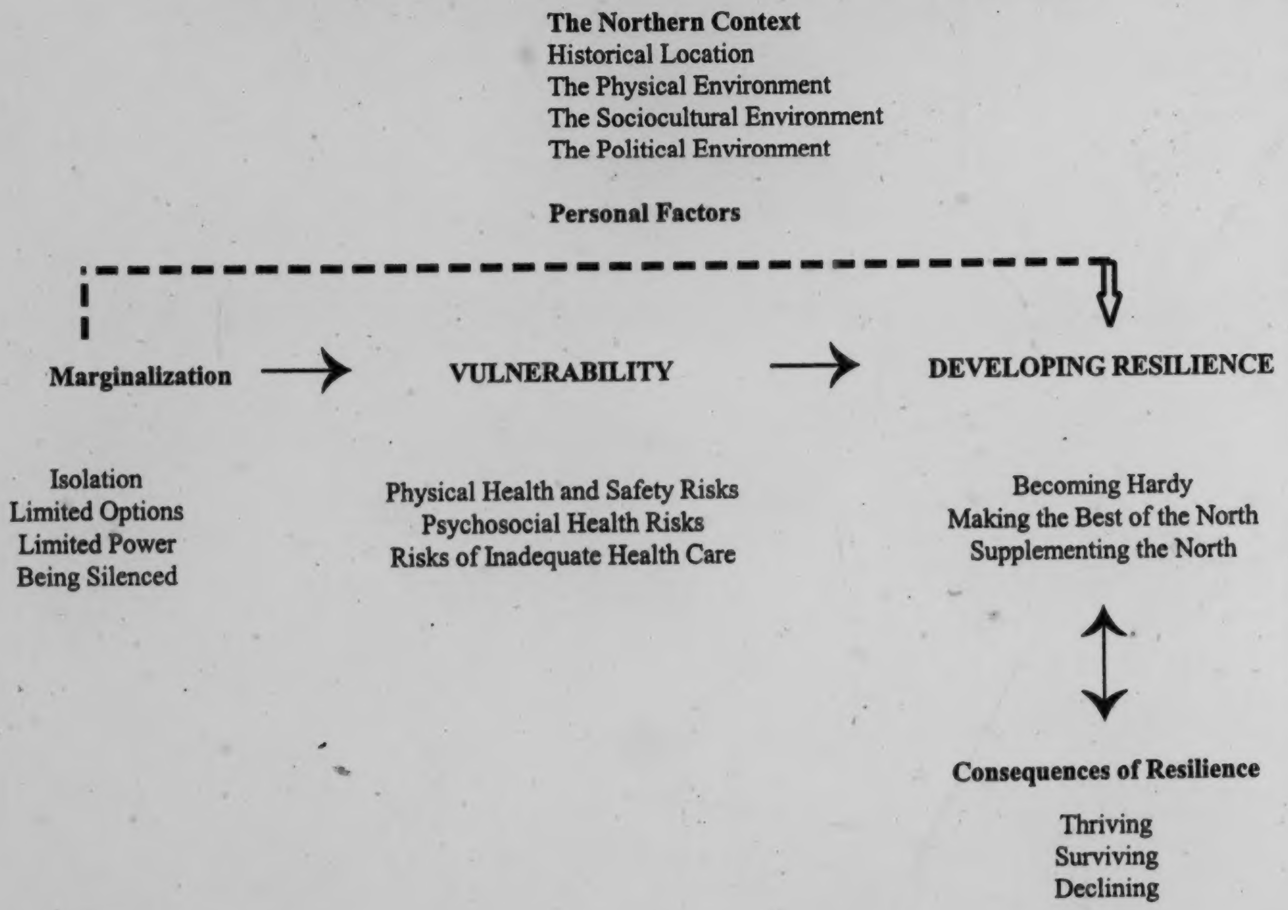
A Brief Overview of the Theory

The intent of grounded theory is to generate a theory that explains a process of how individuals respond to a main concern or problem (Glaser, 1978). The main problem for the women in this study was revealed to be that of vulnerability to health risks. The health risks that the women were vulnerable to were physical health and safety risks, psychosocial health risks, and risks of inadequate health care. Women responded to these risks to their health by developing a process of resilience which included strategies of becoming hardy, making the best of the north, and supplementing the north (See Figure 1 on page 80). Becoming hardy for northern women involves taking a positive attitude, following spiritual beliefs, developing fortitude, and establishing self-reliance. Women make the best of the north by participating in northern activities, making decisions about health care services, seeking education and information, seeking and receiving social support, and working on financial and work issues. Supplementing the north involves being political, and leaving the north, temporarily or permanently. The degree to which women could develop and use resilience in response to vulnerability was affected by women's location within the northern context, the degree of vulnerability they experienced, how marginalized they were, and the personal resources they had available.

The northern context, with its historical location and physical, sociocultural, and political environments contributed to women's marginalization and vulnerability, and both problematized and supported women's abilities to develop resilience. Marginalization was characterized by the women in this study as including isolation,

Figure 1

Developing Resilience: Northern Women's Process of Maintaining Their Health


The Northern Context
Historical Location
The Physical Environment
The Sociocultural Environment
The Political Environment
Personal Factors
Marginalization
VULNERABILITY
DEVELOPING RESILIENCE
Isolation
Limited Options
Limited Power
Being Silenced
Physical Health and Safety Risks
Psychosocial Health Risks
Risks of Inadequate Health Care
Becoming Hardy
Making the Best of the North
Supplementing the North
Consequences of Resilience
Thriving
Surviving
Declining

limited options, limited power, and being silenced. Marginalization, together with personal factors such as physical and mental health status, age, education, financial status, cultural background, and past experiences in marginalized settings influenced the degree to which women experienced vulnerabilities. Marginalization also influenced the degree to which women were able to develop resilient strategies.

As a result of developing resilience, women experienced consequences of thriving, surviving, and declining in behavioral, cognitive, and emotional domains. The degree to which women thrived, survived, or declined was dependent upon their abilities to develop and use strategies of resilience. In addition, interrelationships and influences were found to exist between and among the behavioral, cognitive, and emotional domains. Furthermore, the consequences that result from the process of developing resilience were also found to 'feed back' and affect the ability of women to develop and use resilient strategies.

The concepts that form the central elements of this theory - marginalization, vulnerability, and resilience - have been addressed in previous literature and research. However, these concepts also emerged from the data of this study. A more complete discussion of the conceptualizations of these concepts as they emerged from the data will be presented in subsequent chapters. In the final chapter, these conceptualizations of marginalization, vulnerability, and resilience will be more fully discussed within the context of extant literature.

The Northern Context

The first major concept of the theory is the northern context. The northern context is considered in terms of its historical location, physical environment, sociocultural environment, and political environment. The findings related to the northern context were obtained from documents, media, observations, and interviews with study participants.

Historical Location

Aboriginal peoples have long lived in northern regions in Canada; however, Europeans began arriving in the northern regions in the eighteenth and nineteenth centuries, largely attracted by natural resources such as fur bearing animals, forests, and fish (Coates & Morrison, 1992). Living in the north in these early days required adaptability, flexibility, and quick responses to changing economic, climatic, and human circumstances (Coates & Morrison). Because of these circumstances, and because of the relative absence of material resources, indigenous peoples and early settlers needed to be self-reliant and able to live off the land. Hard physical labor - and lots of it - was the only way to survive in harsh northern environments. This early pioneer work ethic still exists in northern locations. As Casey, one of the study participants, described it, this work ethic prescribes that women carry on the tradition of living off the land by having large gardens, canning, and preserving. However, women today also often work at jobs off the farm and so must find a balance between traditional and contemporary lifestyles.

Northern Canada has variously been portrayed as either beautiful or unattractive, as peripheral to centers of power and civilization or as central to resource-based economies, and as a remote hinterland or as a heartland where people make their homes (Coates & Morrison, 1992; McCann and Gunn, 1998; Southcott, 1993). Nevertheless, Coates and Morrison note that northern regions in Canada's provinces have strikingly similar histories. In northern regions, control has been exerted by outsiders, indigenous populations have been impoverished, the emphasis has been on rapid, profit-oriented development, and local residents have been unable to control their destinies (Coates & Morrison). Fluctuations in the economy and in the political view of northern settings as primarily locations for resource extraction have created northern communities of insecurity and transience. Nevertheless, people do choose to live in the north and to call the northern region home. Throughout the following chapters, comments by several women in this study illustrate their commitment to their northern home.

Resource-Based Economies

Because of the dependence of many northern BC communities on resource-based economies, it is important to consider the development of these economies over time. In a classic study of the stages of evolution of resource-based economies, Lucas (1971) proposed that resource-based communities in Canada evolve through four stages -

construction of the community, recruitment of citizens, transition, and maturity. During the initial stage of construction, the population is very transient and consists primarily of single men. As the community enters the second stage of citizen recruitment, increasing numbers of married workers arrive. Women in this stage of a community's evolution may experience considerable dissatisfaction with the lack of urban and social amenities (Lucas). The transition stage includes increasing stability as control of the town passes from the company to the community, and residents develop an attachment to the community. In the fourth stage of maturity, the community begins to have older residents who represent a stable core of people who view the community as home.

Gill, in her study of northern Manitoba mining towns (1984), proposed a fifth stage in the evolution of resource-based communities, the stage of decline. The 'boom and bust' characteristics of mining towns, for example, are indications of fluctuations in international metal markets. Usually, the decline is temporary. However, factors in recent years have worked to make the decline in some communities more permanent. Increasing societal concern about degradation and preservation of the environment, and the availability of and preference for alternatives, such as plastics, to natural resources have decreased the demand for natural resources, such as forest and mineral products. In addition, as resource-based communities age, forests, fish sources, and ore bodies become exhausted, leading to closure of mines and downsizing of forest and fish industries. Jobs are lost, people move away, and there are fewer resources to sustain communities. During the time of this study, the resource-based communities included in the study were in the stage of decline. Several mines in the north were closing or had closed, and the forestry and fishing industries were downsizing.

Other important historical elements related to resource-based economies include changes over time in population demographics and community resources (Dunk, 1991). For example, because of employment opportunities, northern regions tend to be comprised largely of relatively younger populations who come north in search of work. The presence and nature of these populations influence the quantity, quality, and nature of the goods and services that are available in northern communities at any given time.

When resource-based economies fluctuate and jobs are lost, population demographics change as young people move elsewhere in search of employment. Consequently, the quantity, quality, and nature of the resources available in northern communities declines. During the course of this study, several northern communities, both small and large, lost significant industries, residents, and resources. As expected, smaller sized communities are more vulnerable to these changes than larger more established communities (Dunk).

Other changes over time relate to advancements in technology. Technological advancements, such as improvements in transportation and communication, have increased access to resources over long distances and in harsh climates for more northern people. For example, several women in this study remarked upon the importance of vehicles, roads, telephones, and computers in making their lives in the north safer and more enjoyable. These and other historical characteristics and changes have in turn changed the social fabric of northern communities. Indeed, as one woman in this study noted, the north is becoming a setting where people choose to live, rather than where they "just happened to land and couldn't move on". As a result, stability and community commitment and involvement are enhanced.

The Physical Environment

Geographical Location and Definition

A large part of the Canadian population of over 30 million (Statistics Canada, 2001) lives in the southern part of the country. Fewer than six percent of Canadians live in the northern three-quarters of the country (Bone, 1992). The proportion of Canadians who live in rural and remote areas, which comprise much of northern BC, has been declining (Fellegi, 1996; Mendelson & Bollman, 1999). As of 1996, 22.3% of Canadians lived in rural regions and small towns with populations of less than 10,000 - a decline of 12% since 1976 - and approximately 68% of these people live in rural areas of less than 1,000 population (Rennie, Baird-Crooks, Remus, & Engel, 2000).

This study included women in the Cariboo and Northern Interior health regions of British Columbia, which along with two other health regions have been designated as northern (Report of the Northern and Rural Health Task Force, 1995) (Appendix A).

The northern health regions are geographically vast, yet sparsely populated. For example, the Northern Interior health region consists of 149,532 square kilometers and only 126,516 people; the Cariboo health region consists of 82,475 square kilometers and 70,995 people (Statistics Canada, 1996). These figures translate into approximately 1.17 people per square kilometer. However, because some people live in villages, towns, and cities, the actual number of people per square kilometer is in reality much lower in many rural and northern areas, with no people living in much of the area of the northern regions.

The boundaries of what is considered northern British Columbia are, however, controversial and defy easy definition and description. Some authors state that 'northern' is not a single geographical, physical, or historical zone (Coates and Morrison, 1992). Nevertheless, using various criteria, some definitions of 'the north' have been described in the literature. Using bio-climatic criteria, Usher (1998) identified two environments in Canada: the Arctic and the Subarctic. British Columbia falls within the Subarctic region because it has a July temperature of at least 10 degrees Celsius and it is within the tree line zone (Usher). However, this definition of British Columbia does not recognize the varying bio-climatic conditions within the province. For example, southern coastal BC has the mildest winter temperatures in Canada, with January temperatures averaging about 0 degrees Celsius, while winter temperatures in the northern parts of the province can be similar to those experienced in the Prairie provinces (Robinson, 1998). A more specific categorization of the north offered by Fahlgren (1985) recognizes four zones based on temperature and accessibility to resources: extreme north, far north, middle north, and near north. Both of the health unit regions included in this study fall into the near north zone, which is closest to the southern zone.

A more recent comprehensive delineation of Canada's north (McNiven & Puderer, 2000) used 16 indicators to determine north-south zones. These indicators included such factors as climatic severity, summer heat temperature, number of growing days, length of snow cover season, transportation accessibility, population density, and cost of living differentials. Using these indicators, four north-south zones were determined: north, northern transition, southern transition, and south. The regions included in this study fall within the southern transition zone, with the Cariboo health region being geographically located closer to the south zone, and the Northern Interior health region being closer to the northern transition zone.

A definition of northern can also be elucidated by including elements of a definition of rural, since much of northern BC is rural. As indicated previously, Statistics Canada (1993) defined rural areas as places having populations of less than 1,000 and a density of less than 400 persons per square kilometer (km). The Rural Committee of the Canadian Association of Emergency Physicians (Canadian Association of Emergency Physicians, 1997) defined rural remote as communities that are 80 to 400 km, or 1 to 4 hours transport in good weather from a major regional hospital. Rural isolated refers to rural communities more than 400 km or about 4 hours transport in good weather from a major regional hospital. Using these criteria, much of northern BC could be considered not only rural but also rural remote and rural isolated. The only regional hospital in northern BC is in Prince George, which is several hundred kilometers from most northern communities. Women in this study lived in rural, rural remote, and rural isolated communities, as well as in small towns and urban cities.

The lack of a clear and consistent definition of rural and northern inhibits the ability to describe the distinctive health care needs of rural and northern populations, to forge cohesive political coalitions, and to search for solutions to the problems of rural and northern dwellers (Weinert & Boik, 1995). Nevertheless, a meaningful definition of northern must acknowledge that the north may be "less a real region signified by a name and more a name, a signifier, with historically-variable, socially-defined content" (Shields, 1991, p. 165). Indeed, women in this study and elsewhere (Leipert, 1999) held divergent views about what northern meant and how it could be defined. Elizabeth, a woman in this study who has lived all her life in the north, explained:

> ...when you've really lived up north, this [Williams Lake area] is way south, Prince George is south...[Where there's more] isolation and there's different weather...once you get start getting winter for seven months of the year...when

> you can't go farming any more, you're in the north.

Fred, a woman in the Cariboo region, reacted to my explanation that this was a northern study by stating, " I think it's funny you're saying Quesnel is northern British Columbia. Quesnel's not even in the center...calling Quesnel north is ridiculous." In previous northern research (Leipert, 1999), northern public health nurses defined the rural northern context as " a feeling, a state of mind"(p. 286) and therefore as personally defined. Thus, in their personal definitions of 'north', women may focus on different indicators (McNiven & Puderer, 2000). For example, indicators of climate and accessibility to resources in addition to geographical indicators may help to illuminate the personal and subjective nature of any definition of northern. In short, the various definitions of north in the literature and articulated by the women in this and other studies highlight the fact that defining the north involves relative, complex, and personal understandings, as well as the objective geographical location.

Positive Elements

Women in the study found the physical environment to have positive elements. Northern positive elements include *closeness to nature, slower pace of life, beautiful surroundings*, and *enhanced access to certain opportunities*.

Several women valued their closeness to nature because it provided them with peace and relaxation. As Barbara explained:

> ...it's [nature] right out my window and I don't have to...wade through lines of traffic or smog or anything to find it.... I can sit at my kitchen table and get a view of the mountain and the lake...I was always raised where nature was so close at hand. I've found peace with that.

Women appreciated opportunities to nature watch, to "hear wolves...howling", "smell the sun on the forest floor and listen to the trees singing in the wind", and to experience the natural environment around them.

A slower pace of life is afforded to women in northern communities. Women noted that, in northern BC, there is "less stress, less rat race", "a less hurried, less rushed attitude", and "you can live...ten minutes from work and go home for lunch... it's a better way of life". Signe, a woman in her 70s who moved north in 1952, "fell in love" with the smaller community:

> ...here, everybody's got time to stop and talk...my daughter wants me to move to [the lower mainland] cause she doesn't want to leave me alone here...I couldn't live [there]. I would probably curl up and die....too much traffic - too much lower mainland.

Eileen also enjoyed the slower pace of life in northern BC:

> I wanted more time and more ability to think and be with people and visit and read. And I deliberately chose a different life. I knew that if I moved here I would be able to live more cheaply and have more time to do the things I wanted.

Women also valued the beauty of the north. Carmen, a woman who moved to northern BC from Saskatchewan, explained:

> We love BC!...Whenever we travel in BC...I always feel like I'm a tourist...like I'm on holidays because it's so nice...We did buy a place that's got a beautiful view...this morning...even though it's winter, it was just so beautiful - the sun shining and the frost on the trees...

Margaret, a woman in her 70s who moved from the Prairies to BC, also remarked on the beauty of the north, "...when I was in Alberta somehow it's not as attractive - the forests...it's just plain, where here it's - the mountains and the scenery is much nicer and I rather enjoy that". Elizabeth, who has lived in the north all her life, stated, "This is great. I can go fishing and hunting and isn't it beautiful." Indeed, the mountains and valleys of northern BC are truly breathtakingly beautiful and the destination of tourists from around the world.

The northern environment also provides women with access to particular opportunities. For example, Amelia appreciated the "access to recreational [opportunities] - like right out your back door in many cases people can go skating or cross country skiing..." Alice, a woman who moved in her 30s with her family from Europe to a farm in northern BC, also valued the easy access to recreation:

> ...we never have the desire to leave to go somewhere on holidays because we feel very fortunate...When it's nice here you have the river, you can go swimming, you can go tubing down the river, you can go horseback riding, we have so many options. [Other] people have to pay to do those things.

Eileen left a large city and returned to the north so that she could "Be with my daughter and...my daughter is able to participate in things...all within a very short driving distance".

The northern physical environment provides employment opportunities for men in resource-based northern communities. Such employment is important for women with male partners. Amelia noted, "I guess that's another reason why many of them moved here. There's a mine that opened up here a few years ago". Carmen concurred that "the reason we moved here was my husband took a different job". Indeed, northern BC has long had a reputation as a place for employment in resource-based industries (Robinson, 1998), at least during boom times when these industries are thriving.

Northern BC provides people with real estate opportunities as well. People may move to northern BC because land and housing prices are often cheaper in northern communities. Amelia explained that, "...many of them [neighbors] came from the coast I believe. Land [and] houses were a bit cheaper I guess up here than there". Fred, a woman with physical disabilities who has a limited income, also noted that she has been able to purchase a home, "which is another nice thing in a small town - it's not something you would have done in Vancouver". Eileen, a woman who grew up in the north, then lived in a large American city for several years, and has now returned to the north, explained, "I wanted to be able to buy a house. I could never have afforded that in [the state she moved from]. I've been able to buy a house which is an important security thing for me".

Clearly, the physical northern environment with its large open spaces, sparse population, closeness to nature, natural resources, beauty, and increased access to particular opportunities promotes health and quality of life for some northern women.

Negative Elements

The physical environment, however, also presents challenges. *Climate, distance and geography, pollution*, and *dependence upon resource-based employment* were noted by the women in the study as particularly problematic.

The northern latitudes experience cold weather for long periods of time. Some women stated that cold damp winter weather exacerbates physical conditions such as psoriasis and arthritis. This weather can also lead to isolation and related consequences, as Christine explained:

> Young mothers are housebound, usually because of their children. I see that they have more...depression and anxiety, and I think northern areas have more of that than southern areas. Possibly because you can get out more in the southern latitudes because the weather is nicer.

The winter climate also includes decreased amounts of sunlight which can result in depression. Several women noted the depressive effects of decreased sunlight and of long winters that never seem to end.

Distance and geography also posed challenges for women. Towns are few in number and often separated by many kilometers. Carmen explained, "in Williams Lake...if we wanted to see a big concert we'd have to...travel for three hours". Traveling out of the north is expensive, as Marie explained:

> you first have to get to some place that you can fly from that isn't going to cost you an arm and a leg. Flying out of here is phenomenally expensive. I can fly to Calgary return [to Williams Lake] cheaper than I can fly from here to Vancouver.

Elizabeth noted that when she lived in a remote northern community, it was a 20 hour drive to obtain adequate medical care; flying out of that community was not an option as it "costs as much to fly out of Watson Lake as it does to fly to Australia so it's not an option for a lot of people". Clearly, the physical environment poses challenges to women's ability to travel and access resources.

The geography of the north combined with vast distances through isolated terrain and winter weather create challenges for transportation. Women are often reluctant to drive because of poor road conditions, and the presence of large logging trucks on the roads compounds the problems. Amelia explained:

> I had a Volkswagen Beetle that I used to drive and I was coming to town one day and a truck came by and a rock came [through the windshield] and I have glass all over my lap and I'm thinking, "Oh, this is just unbearable".

In addition, ice and snow create hazards that, when combined with long distances and traveling at night, make driving not an option for many women. Barbara summed up many northern women's perspectives about traveling when she stated:

> I'm not fond of winter driving so that really limits me. I would go to something [in a distant community] maybe in the summer time but as soon as there's a hint that they [the roads] could get bad, I won't drive, so that really strands me here...for six months of the year...it's my own fear of driving on winter roads.

Air pollution was perceived by several women to be a problem in northern communities. Jocelyn and Mary commented on the health effects of air pollution in their communities. Jocelyn stated, "I have done a lot of reading and I'm very concerned about the environment...a mill town is not the healthiest place to live...pollution is a really big factor in Prince George and Quesnel". Mary concurred, "Living here in Prince George is the only time I've ever had this problem [asthma] ...It's never happened anywhere else...I really feel that it has to do with the pollution that's here...due to the pulp mills." Women in northern BC are not alone in their concern for the environment. As O'Gorman and Delaney (1996) noted in their descriptions of the contributions of women to the welfare of people in northwestern Ontario, women in other northern environments have also voiced concerns about the degradation of their air, water, and land environments by resource-based industries.

Although the north contains a wealth of natural resources that provide employment, resource-based employment also can be problematic. The precarious nature of the resource industry causes problems for families who depend upon it. Carmen's husband lost his job when the mine closed, necessitating a move to another northern community where the mines are still in operation. Linda's husband works on a contract basis for a mine that may be downsizing or closing. Consequently, their family income is limited and insecure, and the family may need to move again in search of employment. Frequent moves result in economic and personal costs, such as loss of equity in property and extra expenses and energy to establish a new household (Bowles, 1992).

Job loss due to closure of resource-based industries can also threaten the sustainability of northern communities. Casey noted that as a result of one of the mines closing, "...the population has gone down...the elementary school may close - there's only 33 students there. The fall fair's no longer held [there]". In addition, fewer people means less spending on necessities and luxuries, resulting in a decline in the diversity and quality of goods and services in communities. Thus, rapid social change and fluctuations in community size contribute to an atmosphere of insecurity and decreased access to resources for residents (Bowles, 1992).

For women who make their living on ranches and farms, the financial picture may not be much brighter, as Casey explained:

> Ranching's a really marginal business and if you historically look at the prices of beef over the last 20, 30 years, it's a very poor return...and I don't know who's making money on it but it's not the ranchers...we have 200 acres and we've never had any illusions of making a full living for the two of us on the place.

Robin noted that farming in the north is sometimes overlooked, that "it's not a main income for the area...[like] logging and mining....There's a sense even in the businesses around [in the town] that we're not a farming community".

Thus, features of the physical environment such as climate, distance and geography, pollution, and dependence upon resource-based employment create challenges for northern women.

The Sociocultural Environment

The northern environment also has certain sociocultural characteristics. These characteristics relate to the social, ethnic, religious and other aspects of culture and life style. The sociocultural environment of the north contains both positive and negative elements.

Positive Elements

Two sociocultural elements emerged as positives: *a sense of inclusion and community spirit*, and *a sense of safety*. Several women noted that people in small northern communities tend to be friendly and inclusive, and have a sense of community spirit. Friendly smiles, kindness, helpfulness, and having the time and inclination to stop and talk were all mentioned as positive aspects of northern communities. Various explanations were offered for these behaviors. Signe thought that northern friendliness has developed due to the harshness of the environment:

> Because years ago it was hard to live here, you had to be tough to live here. And you never locked your door. People would walk in, "Hi, coffee pot on?" So you make a pot of coffee, sit down because...there was no TV...there was just people. You had to survive together.

Similarly, Chris believed that people were friendly "because we need each other. We're not afraid to reach out I think, whereas in a larger community people may be worried about being refused". Amelia pointed out how getting to know people contributes to community spirit:

> ...people who live out in the country are more caring I think...and you get to know them. And when you get to know people, usually you get to like them. Like in a city when you don't know someone, there's just a face there somewhere and it's very impersonal.

Several women remarked that there is a closeness with friends, almost a sense of family, in northern communities. This closeness may occur in rural and farming areas where there are sparse but stable populations and fewer family ties (McNeely & Shreffler, 1998), social situations that are not uncommon in the north.

Northern communities may be perceived as safe, especially when compared to large urban centers. Eileen, who has moved back to northern BC from a large American city, enjoyed the safety of not having to "make sure, double sure, everything's locked in your car before you go into the grocery store because it might get ripped off by the drug addicts in the neighborhood". Eileen also stated:

> I think it's tremendously safer here...The last New Year I spent there [in the US]...I remember lying in bed at midnight...and all the semi-automatics were going off... [I was] just praying that nothing would come through our window or my daughter's...First of all, the danger of that. Second...the fact that we were surrounded by gun fire revealed how many people had guns. Yeah! It's safer here.

Jocelyn, too, stated that "it [northern BC] feels to be a safe place for me and my cats and horses. There's such a feeling of tranquility".

Negative Elements

The positive sociocultural elements of northern BC are counterbalanced by several negative elements. *Overfamiliarity, outsider status*, and *lack of resources* were the primary negative sociocultural elements noted.

In spite of - or perhaps because of - the vast distances between people and communities in the north, overfamiliarity can result, especially in small communities. This overfamiliarity occurs when 'everyone knows everyone else', a situation that is common in small, isolated, and relatively stable communities (McNeely & Shreffler, 1998). While familiarity can facilitate social support, it can also result in a lack of anonymity and confidentiality (Lee, 1998a). Park explained how being known can interfere with women's abilities to access services:

> I mean if somebody's car was parked at the woman's center...people kind of assume that she's gone there to get help...When you're going to see a counselor, you may be seeing her in other social functions as well...So women probably feel their confidentiality is at stake...in bigger cities, nobody knows where you're going for help.

Jocelyn works in a human services position in a small community. She explained how being known and visible in a work role affects her social life:

> I live on my own out in the country...I do have to address safety issues in my life...I have just recently had to change my telephone number because I've had clients....[who] tracked me down...I am very picky and choosy about what I do

> and even what stores I go to...

In addition, Jocelyn is careful in deciding which community groups to belong to because she doesn't "want to be ending up working with my clients on a social basis". Thus, while familiarity can facilitate social support, overfamiliarity can also jeopardize women's well-being.

Being an outsider in a community can also be a problem for women in small northern communities. An outsider is someone who is different from the dominant community culture and characteristics, unfamiliar or not well known, and unconnected to family or other personal ties in the community (Bailey, 1998). Conversely, an insider is someone who has been a long time occupant of a community and who is intimate with the community's norms and assumptions (Myers, 1998). Several women new to northern communities noted difficulties finding social support because of their outsider status.

Achieving insider status can confer acceptance and inclusion. Casey, an 'outsider' woman, suggested that marrying an 'insider' man can facilitate inclusion:

> ...my father-in-law was very highly regarded in the community...I took my husband's surname when we married and so you know, whenever you're introduced by name - oh, are you related to? - so that was definitely an in. And I think it expedited my acceptance into the community.

Rosie pointed out that the process of becoming an insider in a community requires an initial acceptance of the community norms:

> you have to prove yourself as being acceptable. You have to meet...the principles of the community. You have to not be intrusive, you have to take people as they are, you have to know where the hierarchy is in a bigger community...the political base of the community. You have to be willing to respect their attitude, even if you don't agree with it...there's got to be that acceptance period... Especially if you come from the southern part of the province or back East... once you're accepted, you're family.

Lack of resources was another negative aspect of the sociocultural environment of the north identified by the women in the study. Resources for health care, employment, education, recreation, and entertainment either do not exist, or they exist in inadequate quantities, qualities, and varieties. A limited range of goods, services, and opportunities seems to be characteristic of northern communities (Bowles, 1992; Coates & Morrison, 1992). This limitation is due to factors such as small populations and remote locations. Lack of access to resources and its resultant effects will be addressed more fully in Chapter V. However, it is important to note here that it is not only smaller communities in the north that are experiencing a lack of resources. Increasingly, larger communities are also experiencing loss of resources, as Mary explained:

> ...even in communities that you think are not so isolated... these people [in larger centers] are beginning to be isolated [from resources]...if it's deteriorating where it's not isolated, it's [certainly] deteriorat[ing] even further in the more isolated communities.

It is also significant that during the course of this study, the forestry industry experienced a profound 'bust' period, and several mills and mines closed with subsequent loss of several hundreds of jobs in northern BC. This downturn in the economy resulted in the loss of human as well as material capital from the north, thus compromising the availability of resources and the health of all northern people.

The Political Environment

The political environment relevant to the northern context can be characterized by two elements: the undervaluing of the north and the undervaluing of women. These elements reveal values of non-northerners as well as northerners.

Undervaluing of the North

The perspectives offered by the women in this study provide important information about the valuing of the northern environment. The women noted several aspects of the undervaluing of the north including *misunderstanding, exploitation, lack of commitment,* and *lack of political power and support*.

Signe summarized many northerners' sentiments about southern perspectives and misunderstandings about the north when she stated:

> ...the people in the lower mainland think British Columbia ends at Hope [a small town in southern BC]. They figure anything north of Hope is just boondocks...People...still think we're mukluks and sleighs, sled dogs. We're still in the 1890s here as far as they're concerned...They figure [Prince George, the largest city in northern BC] [is] a little one horse town where the horse died. [Southern attitudes are like that] everywhere [about] the north, not just Prince George.

Undervaluing of the north is also evident in the resource exploitation and inequity that exist between the north and other regions of the province. Christine noted, "the government has to somehow divvy out more evenly so that care is accessible...We [northerners] don't [get our share of resources]. We provide...all sorts of stuff for the province, but we don't get back in return".

Several women identified a lack of commitment to the north by human services professionals as an important manifestation of undervaluing. Christine explained the consequences of not being committed to northern life and practice when she stated, "...Some of the people I've had to deal with up here...it's like they're at the end of their rope...they hate it [here]. And when you don't like where you are you don't do a good job". Jocelyn described how a high turnover of health care providers compromises continuity of care and increases the personal responsibility northerners must take to maintain or regain health:

> I have never gone to the same doctor twice...I was getting my information from books but I certainly was not getting my information from any medical doctor here because I wasn't seeing the same one twice. I've really felt that the burden of anything to do with my health is really on me...I envy the women who have come up from the lower mainland or the Okanagan and have a doctor back there...as of this minute, nobody [no physician] knows me here...It seems that every time I go in I have to start all over.

The high turnover of human services providers suggests that the north may be valued by some as a 'stepping stone' to employment elsewhere. Elizabeth noted "with physicians, the big money's down south, and [living in the north] is a real life style thing and I guess they think they don't need to live it", and for some physicians, "they're trying to get in [the north] - once [they're] in, [they're] trying to get out". Elizabeth suggested that the north provides excellent learning and experiential opportunities for physicians and others, but northern limitations such as isolation and limited resources often result in people not staying for the long term. A high turnover of providers compromises care.

Undervaluing of the north can lead to decreased resources and services, which creates a situation where northerners themselves develop dissatisfaction and expectations to leave. For example, Leah, a young woman who recently graduated from a high school in the north, stated that "the high school mentality here is 'Get the hell out of [this town]'. That's all anyone thinks about, talks about". Ruhi also noted that "most kids go to Vancouver, they never come back".

Lack of political power and support for the north was also recognized by the women as evidence of being undervalued. Sparse populations in the north and political attitudes about the north result in decreased representation in political elections and decisions. Elizabeth explained:

> ...that's probably the biggest thing is the political attitude...[it's] that we don't exist. There's not enough of us [in the north] to vote to make a difference so we're just totally ignored. But we're here paying out taxes the same as everybody else.

Elizabeth's comments reveal not only the lack of political power in the north but also the lack of political support for the north. Almost all of the women reported that the north is under-resourced by the provincial government, particularly regarding health care services. Casey summed it up this way:

> I think the northern communities and not just women are neglected. I think we're an afterthought as far as resources being distributed...'Cause I've lived [in] both [north and south]....Economically...the work that's done up here is contributing to the overall economy...a lot of resource[s] [in the north]...that's what keeps the

> province going...even though most people live in the south...There needs to be support for healthy lifestyles up here as well.

The lack of adequate resources in northern communities can perpetuate the undervaluing of the north by northerners and non-northerners alike. As a consequence, undervaluing of the north can remain entrenched, especially in times of resource-based economic downturn, making a recasting of the value of the north problematic.

Undervaluing of the north by northerners and non-northerners has been well documented. Discussions in the literature about the north (Coates & Morrison, 1992; McCann & Gunn, 1998; Southcott, 1993; Weller, 1993; Zapf, 1991) suggest that southerners often view the north as a frontier and hinterland as opposed to the northern view of the north as a home and heartland. This dichotomy is often the source of much misunderstanding and controversy between the north and the south (Weller). Northern regions of Canada's provinces may be seen as 'have' regions because they are the source of great wealth based on their natural resources (Southcott). However, northern regions often experience 'have not' conditions such as poor social conditions, the under-resourcing of health, education, social and other services, the persistence of paternalistic and colonial perspectives that dominate and control northern environments and ways of life, and depressed or unstable economies (Arges & Delaney, 1996; Coates & Morrison). These conditions are perpetuated by the lack of the electoral base needed to obtain political power and make needed changes (Coates & Morrison; Weller). Consequently, the northern context has become and remains the product of exploitation, underdevelopment, and colonialism (Zapf) and is compromised in its ability to control its destiny (Coates and Morrison).

Lack of commitment to ongoing employment in the north has also been documented by others. In their discussion of ethical dilemmas in northern social work practice, Delaney and Brownlee (1996) note that human services and other knowledge-based workers in northern environments may accept employment in the north with the intention to leave at the first opportunity. Workers may exploit the ready employment in the north to gain experience, but may not value the north sufficiently to stay long term.

Thus, northern communities often benefit very little or not at all from the rich experience gained by workers in their communities. This type of situation where the north is undervalued by workers compromises consistency of care and the building and sustaining of northern communities (Delaney & Brownlee).

Undervaluing of Women

Several women in this study spoke about the undervaluing of women in northern environments. Dimensions of this undervaluing include the *undervaluing of women's roles and perspectives*, and the *attitudes of physicians*.

Undervaluing of women's roles and perspectives

The undervaluing of women's roles and perspectives is revealed in the 'redneck' attitudes that are prevalent in northern communities. Women described these attitudes as favoring men's values, interests, and behaviors: emphasizing male employment and male-oriented activities such as rodeos and hockey; and valuing traditional and oppressive roles for women."It's a really redneck mentality here", said Leah. "The man's the breadwinner here and...I don't see a lot of choices for women here...here it's just like an 'old boys' club', especially for women who live in rural areas". Jocelyn noted that, like northwestern Ontario, "the environment here...[has] the same redneck mentality...logging, poor dirt farms, ranches....The people [men] work in the mill and they make the money and they have the expensive toys...".

One aspect of the undervaluing of women in 'redneck' northern environments relates to the undervaluing of women's roles. For example, Eileen felt that mothering wasn't respected in the north, "I noticed a lack of respect for me as a mother and as a thinking person, particularly by men in the community...I think it's because a lot of women here still struggle to respect themselves as mothers". Therefore, although rural and isolated communities may subscribe to traditional roles for women (Bushy, 1990b, 1994), such as mothering, these roles may in fact not be valued.

Several women expressed the view that women's voices and perspectives are often not valued or respected in northern communities because these communities are segregated by gender and dominated by male values, priorities, and roles. Eileen explained:

> There's this idea that men and women are on different sides...I think it's, partly, pure sexism...That women don't have anything interesting to say...I think also, partly, there might be another element to it which is there isn't easy mixing between the sexes here...Everything is much more gender labeled...

Rhoda felt that northern male attitudes foster silencing and role restriction for women:

> I think that women's voices aren't really heard...the woman's place is...in the house chewing the leather (laughs)...it's about that sign I saw [when I was traveling]...'Lexington, Kentucky: Where Men are Men and Women Are Glad Of It'. That's the kind of attitude around here...that's partly why there's violence and drinking and it's like an old time western movie.

Thus, 'redneck' northern communities that subscribe to traditional gender roles may not only be restrictive but also dangerous for women.

The undervaluing of women's perspectives and roles was viewed by some women as resulting, in part, from male-oriented resource-based employment in the north. Although some resource-based companies may be hiring larger numbers of women for more diverse jobs, this does not seem to be the case in northern BC. Eileen explained:

> ...the resource-based workplace isn't integrated in terms of gender...people talk about, well, there's this young woman who's been hired on casual weekends at the mill - occasional breakthroughs. The pulp mills are male work places...and the offices are run by women...I don't understand why these workplaces are so differentiated in terms of gender. Isn't it illegal? Don't women want to make more money?

Eileen also noted that some female students had been hired into well paying jobs at the mill but that "if you're going to be a real woman (quotes around that, right) and be married and have a family or be a mother, you don't do that kind of thing".

Small northern communities do not have many opportunities for well paying and satisfying work for women. Jobs for women tend to be in low status, traditional, and low paying sectors (Heald, 1991; Wall, 1993), which reflects the undervaluing of the work that women can and do accomplish. In addition, gender segregation at work can potentiate and sustain gender segregation at home and in other aspects of society, such as in cultural and recreational pursuits. Indeed, Rosie felt that the traditional female roles of cooking and cleaning - if these are women's only options - help to sustain northern women's powerlessness and traditional gender role expectations:

> in a lot of cases, women - and I hate to say this in this day and age - women don't feel they have a lot of power in a lot of rural communities. They either cook and clean, it's like you're stepping back in time 40 years.

Clearly, comments such as those of Rosie and other women in this study indicate that the northern environment, by undervaluing women's roles and perspectives, restricts women's opportunities and quality of life.

Attitudes of physicians

Undervaluing of women in northern communities is also revealed in the attitudes of physicians. Several women noted that physicians who practice in northern settings often do not respect women and denigrate or exclude women's involvement in health care. Rosie summarized what many women in the study believed, "A lot of them [physicians] don't have much time for women...". Although many of the women expressed the desire to be equal partners with physicians in their health care, this type of partnership was rarely enacted. For example, Rhoda related an experience she had with her former physician:

> Did I tell you what my ex doctor said to me when I said to him, 'I really want to discuss these [menopause] sweats'?...I'm having horrendous sweats...and he said, 'Frankly, I'm not interested in your sweats'...And I said, 'Well, you know something - why the hell should you worry about my sweats cause you'll never experience it. Good-bye'.

Undervaluing women's desire for information and quality care resulted in women becoming frustrated and angry, seeking care elsewhere, or foregoing care altogether.

Even in life-threatening situations, where patient knowledge, control, and involvement are crucial, women were undervalued by physicians and were often excluded from active participation in their care. Several women described these experiences which will be more fully articulated in subsequent chapters. Here I offer Vicki's experiences as an example of the types of undervaluing that northern women are often subjected to by physicians in health care situations. Vicki describes her interaction with physicians after being diagnosed with cancer:

> I asked for a second opinion from the other surgeon in town. He was...quite rude. He wanted to know who I thought I was that I should ask for a second opinion and he said, 'I don't understand what you're upset about'. Quite arrogant, and he...told my husband and I to prepare ourselves for the fact that it was a cancer.

A later experience with her family doctor reveals the lack of respect, concern, and care that northern women may be faced with when they visit their family physicians:

> ...he turned to me and he said that it was absolutely none of his concern about doing followups for patients, and didn't I know that he was a very busy person, and didn't I know that it was my responsibility if I wanted a follow up with a specialist, and he had no more time to spend on my file...

Vicki noted that certain physicians, especially if they are not from Canada, "are not used to being questioned in any way by anyone, least of all by a woman...we do not get the courtesy, the respect, or anything else I feel we deserve". Vicki felt that physicians' lack of respect for women undermines women's abilities to access information that ensures quality of care:

> If I'm going to have my dog have anaesthesia or anything done, I want to know that that vet's reliable but the doctors here don't afford me the same opportunity to say, 'Ok, tell me how many people you've done this surgery on'. That's not a courtesy that I find that I have and I do feel that gender plays a great deal in this now.

For major health issues, Vicki recommended that women "Don't go north, go south. The doctors in the north, from my experience, make you feel like they're doing you a major favor by being here".

Although female physicians were often perceived to be more caring and respectful of women, female physicians are rare in northern communities, and their practices quickly fill up. Thus, women often turned to other health care practitioners such as nurses and homeopaths, who were more likely to value them, and from whom they received more respectful care.

Northern women's perspectives about how women are valued in northern environments are reflected in the literature. Gill (1984) found in her research in northern Canada that women may often be in northern communities as appendages to their husbands who are employed in the resource sector or in ranching and farming. Communities in the north, therefore, are often oriented to the needs and interests of the male worker. Sachs (1994), in her discussion of rural women in the US, suggested that the undervaluing of rural women may persist because women may not see their oppression or they may choose not to address issues of undervaluing. In patriarchal societies, such as those that exist in many resource-based communities, women may be encouraged not to see their subordinate status and to accept their lot (Sachs). Women may be particularly vulnerable to pressures to conform to the male-dominated status quo if their male partners are employed within the resource-based and rural sectors because resistance by women could reflect negatively on their husband's access to jobs (Sachs). In addition, women in rural environments often lack access to formal power structures (Sachs; Wall, 1993). As a result, it is more difficult for women in rural northern communities to become involved in political activism to change the valuing of women.

Northern women's experiences with health care providers is only beginning to be addressed in the research literature. Research in BC reveals that northern women are often not informed, included, and respected in their care, particularly by physicians (Anderson et al., 2000; Jordan, 1999). This research expands the limited data base on northern women's health care experiences.

Summary

This chapter has provided a profile of study participants and a brief overview of the theory developed in this study, followed by an in-depth discussion of the Northern Context. The Northern Context includes both positive and negative aspects. The historical location of the north, particularly as this relates to its resource-based economies, and the northern physical, sociocultural and political environments can limit women's opportunities and marginalize northern women. The following chapter will describe findings that articulate this marginalization.

CHAPTER V

FINDINGS: MARGINALIZATION

The physical, sociocultural, and political environments and the history of the northern BC context contribute to the marginalization of northern women. In this chapter I discuss findings related to the marginalization of women within the northern British Columbia context.

Marginalization, as described by the women in this study, relates to feeling and experiencing inequitable access to resources necessary to achieve and maintain health when compared to non northern women and to men within the northern context. Gender and geography form the basis of northern women's marginalization. Marginalization is characterized by four major aspects: isolation, limited options, limited power, and being silenced. The degree to which women experienced marginalization depended on personal factors such as physical and mental health status, age, education, finances, cultural background, and past experiences in marginalized settings. The following description represents the multi-faceted mosaic of marginalization that women in the study experienced and described.

Isolation

Women in northern BC experience marginalization through isolation. Women are isolated by *the physical environment* and *the social environment.*

The Physical Environment

Women in northern BC are isolated first and foremost by the physical environment. Long distances and inclement weather compromise women's ability to communicate or be with others. Several women spoke about the difficulties of traveling in winter because of dangerous road conditions. Travel in the north is also risky due to the presence of wild life and large vehicles such as logging trucks. In addition, women's generally smaller stature and limited strength and stamina compromise their ability to remove snow from driveways and roads. Distance further increases risks. The longer the distance to travel, the more danger and isolation some women feel. Carmen explained:

> ...if you know that you can go out once in a while...it makes it a lot easier than if you're totally stuck there...I mean, this isn't terribly remote but if you were in say like in the Chilcotin...they're a long ways away from places...you'd have to work harder at keeping yourself busy and keeping yourself so that you don't get depressed.

Communication may be enhanced with telecommunications. However, telephone calls, both local and long distance, can be expensive. Because the usual telephone communication may not be available to women in remote settings, they may be compelled to use more exotic types of telephone communication, such as radio phones. Rosie, a woman in the study who needed to use a radio phone because of her remote location, explained that each telephone call into and out of their home costs 50 cents a minute for local as well as long distance calls. Consequently, she and her husband changed to using a cell phone which is less costly. Nevertheless, even with a cell phone, snow and lightning storms still compromise Rosie's ability to rely on the telephone. This can be particularly problematic because of the extreme remoteness of her location and the distance to resources such as medical care.

Access to telephone communication, however, is not always helpful or desirable. For some women, contact with friends and family in warmer southern locations may serve to emphasize the remoteness, cold, and other negative aspects of the northern environment. As Carmen explained:

> When we're in the throes of winter, I don't even want to phone my friends and talk to them because I don't want to hear... "We went golfing"...when we've still got snow...then I have to make myself think about the good points about being here. And that can be tough.

Carmen's use of the word 'throes', which is defined as "a hard or painful struggle" (Mish, 1994, p. 1229), indicates some of the depth of the challenge of living in the north.

The Social Environment

The social environment also contributes to northern women's isolation by *isolating women from others* and by *creating insider/outsider status*.

Isolating Women From Others

Traditional values regarding women's roles can foster the isolation of women from each other. In some northern communities, women are 'permitted' to associate in women-only groups for traditional women's activities such as child care. However, women-only associations for other reasons, such as for self-help, may be seen as problematic, perhaps because they are perceived as 'subversive' or threatening to men's roles or the status quo. For example, Rhoda developed an Alcoholic Anonymous group for women only to prevent possible revictimization because, "there are things [such as]...sexual abuse...sexual dysfunction...and relationship issues, that shouldn't be talked about in a mixed group". However, the community became "enraged...How dare you!" Rhoda felt that the community outrage may have occurred because women-only events were relatively new in that community, and because men felt excluded. Thus, new ways of being, such as women-only events, may be seen as threatening in some communities.

Undervaluing of women's roles and perspectives may isolate women in other ways. Women's resource centers in small northern communities may be dissuaded from assisting women because of community attitudes about women's roles and women's relationships. Park explained that the local women's center in her community has a "stigma" attached to it, "people have the perception...that [they're] a bunch of, you know, men hating, bashing, lesbian women...(laughter)...and [that the Center is] out there to rip [the] family apart...a lot of women and a lot of men are seeing [the Center] as very radical". Park also stated:

> There's more resources, and diversity is more accepted, in bigger communities or urban communities than in smaller northern communities...I'm just think[ing] of homosexual issues in smaller communities...[these communities] don't really provide the women...the safety and it's going to affect their mental health, emotional health and, of course, their physical health...because they're

> living in a closet...if people are not accepting.

Other research in northern BC confirms that lesbian women can experience isolation and subsequent exclusion as a result of traditional values and lack of options in northern communities (Anderson et al., 2000). Thus, sociocultural environments in small northern communities can discourage women-only events and women's participation in them, thereby sustaining women's isolation.

Women's isolation from each other also is affected by undervaluing of women at the provincial level. Park noted that women's programs are not valued by the provincial government, as evidenced by the unstable and chronic underfunding of women's programs. She expressed concerns that a change in government could threaten even those programs that do exist:

> If the NDP government goes, we don't know what's going to happen to the Women's Ministry. That's probably going to be the first one to go, I bet...because women's programs are not valued. We're considered to be... a special interest group (laughter).

Park's sense of the political culture proved to be sound. A provincial election was held subsequent to Park's remarks. The NDP government was not re-elected, and the new government eliminated the Ministry of Women's Equality as one of its first acts. Although women make up slightly more than half of the population in BC (Provincial Health Officer, 1996), the lack of adequate and consistent political support for women's programs reveals the willful lack of commitment to women by elected provincial representatives in BC.

In addition to isolating women from women, the northern social environment also isolates women from men. Women attributed the social division of the sexes to the dominance of the male culture in the north. Marie stated, "...where we are here we have...loggers, miners, ranchers and...there's this sense among [them] - there's this macho sense, there's this real male camaraderie and it excludes women." Exclusion of women and segregation of the sexes can sustain and foster isolation and oppression for women (Hall, Stevens, & Meleis, 1994). Rhoda agreed that northern male attitudes affect gender relations:

> I think that women are still objectified big time...We've got a logger mentality...if you've ever gone out on a Take Back the Night Walk. I've done it only twice here and...I've been swore at by men on the street and they've spat at you.

In addition to discouraging women-only events, these attitudes and behaviors do little to foster social connectedness with men.

Creating Insider/Outsider Status

Outsider women who are new to the community or who have identities, associations, and experiences that are seen to be somehow different may experience more social isolation and marginalization than women who are seen by the community as insiders, as women who subscribe to similar values as the community. Being an insider or an outsider in the community may influence women's isolation in terms of their acceptance and social support. For example, Casey, a woman from outside the north who married an 'insider' man whose family enjoys a long and distinguished presence in the community, felt that her marriage to a member of the community "expedited my acceptance into the community". Lillian, a woman who moved to the north in 1924 and who has lived in her northern community for 39 years and thus could be considered an insider, enjoyed the "smiles and helping hands. Everybody is so friendly to me".

Outside and insider statuses are created in several ways. Christine explained that a lack of familiarity with community members often infers an outsider status:

> ...when you first move up here...you don't have the network of people that you may have had....You have to develop that and it takes time. Small communities may be very friendly once you get into them, but they can be very cold as well.... Possibly they want you to prove yourself.

Leah noted:

> the clubs get really cliquey...they don't really let anyone in...Like you have to be friends with someone to get in so you can't be a new person and join this book

> club to meet people...I don't know if it's just...they're comfortable with the people they know...

Outsider status is also experienced by women from cultural minorities and by women who subscribe to alternative beliefs and life styles. Mary, a mother and human services worker with an Aboriginal background, described several instances where her children or her clients "tell me incidents that have happened where they have had to try to defend themselves against people who are not of the same race as them". Mary does not believe that prejudicial attitudes are improving. Ruhi, a young woman from India, believed that prejudice sometimes exists when immigrant people attempt to find work, "I have heard from some of my friends that they [employers] were bad because they [the job applicants] are East Indian or Chinese or some [other non-Caucasian race]". Ruhi also noted prejudice within the East Indian community, such that new immigrants from India may be pressured by the East Indian community in Canada to learn English and conform to the Canadian culture. Women who are lesbian and women who do not subscribe to dominant religious beliefs and who do not have children may also be treated as outsiders and excluded in rural and northern communities. In addition, women who attempt to return to a community after leaving for educational or other purposes may find that they have become outsiders because they now subscribe to different norms and values. For example, Eileen had difficulty feeling accepted and included when she returned home from a large American city to a small northern community.

Outsider status may be perpetuated by and influence employment opportunities. For example, Leah noted that for women new to her community, "it is so hard for them [in their jobs] because they didn't grow up here and people know that...You have to be friends with someone to 'get in', you can't just be a new person [to be included]". Indeed, outsiders may be viewed as 'marginal' people who live in the community but are not seen as truly part of the community (Lee, 1998b). Outsider women, then, could experience greater social isolation and marginalization than insider women.

The size of the community may also influence feelings of northern social isolation. Small communities may be more contained and therefore better able to articulate common values and commitments. As a result, it may be easier in these communities than in urban settings to identify those individuals who do or do not subscribe to similar values. For women who do commit to community values, such as Casey who actively engages in ranch activities and Lillian who has children in the community, there may be a greater sense of belonging and fitting in, and a greater sense of community acceptance and support. Northern social isolation, then, may be a combination of a number of factors, including size and location of the community, length of residence, previous and present connections within the community, and personal and community values, commitments, experiences, and associations.

To summarize this section, isolation is influenced by the harsh physical environment and by the size, values, and beliefs of the social environment; these influences can serve to isolate and marginalize northern women.

Limited Options

Marginalization is also characterized by limited options of resources such as *goods, services,* and *education*. These resources are limited in terms of their quantity, quality, and diversity.

Goods

Access to goods of all kinds is limited in northern communities. Goods that are particularly difficult to find include food and clothing. If these goods are available, then they are often more expensive than in southern urban locations. There seems to be a direct relationship between the size of a community and the quantity, quality, cost, and diversity of the goods. Linda, a mother of three who lives in a small northern community, explained:

> I find groceries really expensive here...for clothes...it's either one extreme or the other here. You're either buying the really low, low quality stuff or you're paying top dollar...sometime I'll say, "Well, why don't we wait until we make a trip to Prince George...

Prince George, the largest city in northern BC, provides greater diversity in quality, quantity, and cost of goods and services, which is lacking in many small northern communities.

Lack of choice in food and clothing is particularly problematic for women with special needs. For example, there is no store dedicated to selling clothing for petite women anywhere in northern BC, including Prince George. Barbara, a woman with extreme allergies who lives in a small northern community, stated that, during the first year of her illness, she could find very little food in her community that she could tolerate. Fresh fruits and vegetables and non-processed foods were particularly scarce and costly. In the winter she purchased preserves and frozen food from people who had gardens. In addition, she would ask friends who were making the three hour trip to Prince George to purchase organic food, although this was very expensive. Consequently, in the spring of that year, Barbara's diet consisted of yogurt, potatoes, bananas, rice cakes, and moose meat.

Small communities in northern BC are very restricted in their provision of other goods such as furniture, books, and children's wear. For many northerners, Prince George serves as the major source for goods of quality, quantity, and diversity. However, Prince George itself is limited in its ability to offer adequate goods, and travel to Prince George requires considerable time, finances, and effort, particularly in winter months when roads may be in poor condition. On the other hand, small communities do seem to have a greater preponderance of goods related to the northern male lifestyle. Hunting weapons and camping equipment, outdoor recreational vehicles, automobiles, and farming, ranching, forestry and other resource-based supplies are readily available even in small northern communities. Here again, however, choice is restricted in terms of quantity, quality, and diversity.

Services

Services of all types are limited or nonexistent in the north. However, women in the study especially noted limitations in the quantity, quality, and diversity of *traditional and alternative health care services, health promotion and disease* *prevention services*, and *other services and resources.*

Traditional and Alternative Health Care Services

Traditionally, health care services in Canada have primarily focused upon and been dominated by hospital-based and illness-related care. Areas of traditional and alternative health care services that the women noted as problematic in northern BC were related to the *availability of physicians and nurses*, including female physicians and specialists; *quality of care*; *availability of hospital, diagnostic, and mental health services*; and the *accessibility of alternative health care services*. During the course of this study, the depth and scope of an acute provincial, national, and international nursing shortage became evident as highlighted by national, provincial, and local media and professional literature (see Bushy, 2000; Ramp, Kulig, Townshend, & McGowan, 1999). This health care personnel shortage, coupled with the other health care service issues noted by the women in the study, has resulted in further marginalization of northern women who live in the marginalized and underserved geographical area of northern BC.

Availability of physicians and nurses

Several women in the study remarked on the difficulty of obtaining consistent care from physicians, largely as a result of the inability of northern communities to attract and retain physicians. Jocelyn, who has lived in her community for seven years, described some of the difficulties of not having consistent and adequate physician services:

> I have never gone to the same doctor twice in Quesnel. I don't have a doctor that I can call up...I've really felt that the burden of anything to do with my health is really on me...I envy the women who have come up from the lower mainland...and have a doctor back there...as of this minute, if I had something wrong with me, nobody [no doctor] knows me here...It seems that every time I go in, I have to start all over.

There is also limited choice in accessing female health care providers in the north. Many women preferred to see a female health care provider because they felt that female nurses, female physicians, and other female health care providers could identify more readily with women's concerns. Several women in the study felt that access to care would be enhanced if female health care providers were more readily available, as Rosie, a nurse who lives in a tiny remote community, noted:

> I find that the ones [women] that go to the women doctors are much better at saying things about their health. A lot of women are embarrassed to talk to a man doctor still...Where they'll talk to a nurse, or they'll talk to a counselor and they'll just unload everything. However, female physicians are very rare in northern communities.

As favored as female physicians might be, they are extremely rare in the north, and their practices fill quickly.

Similarly, specialists are rare or nonexistent in northern communities. Casey stated:

> What it means, living up here, there are very few specialists...it's really hard keeping a specialist in a small town...like we go through surgeons, it's like a revolving door here. We're just lucky to hold on to them for as long as we can.

In addition to surgeons, other specialists who are in short supply include gynecologists and psychiatrists. Psychiatrists from larger centers may visit small northern communities periodically but, as Marie explained, this type of service is less than satisfactory:

> We have a psychiatrist that comes in once every six weeks. And he treats for three or four days, however long he stays...[he] treats...I mean, just tons of people. How can you be effective? It just doesn't make any sense. You can't...It's not possible.

Indeed, all medical specialties are only available on a limited basis or not at all in the north. Due to low populations in small communities, specialists can most readily be found in Prince George, the largest northern city. Therefore, women who live outside

Prince George must travel to reach services there or in other southern locations. However, even Prince George is not staffed with a wide variety of medical specialists and, with the acute shortage of medical and nursing personnel nationally, specialists are leaving Prince George for employment elsewhere.

The limited access to physicians in the north poses particular problems for women. Because a small community usually only has one or two physicians, women are compromised in their ability to seek a second opinion or to change physicians. Christine's comments illustrate some of the difficulties northern women have in accessing care because of limited choice:

> I've had doctors tell me that my problems are all in my head, when they've only met me just once or twice and they know nothing about me. That's probably true in southern latitudes as well, but you have more choices [there]. You don't like your doctor, you can find somebody else. Up here, there's not that much choice.

Regarding nursing services, several women in the study expressed the view that they would use nursing services more if more nurses were available. However, women in the study were often unaware of what nurses could do, as Eileen stated, " I don't think the public understands...what nursing can do...I don't know what the public health nurse does, if you don't have a baby". When I suggested that nurses could provide more care such as screening for cervical cancer and other services, many women stated they would welcome such services, rather than seeing a male physician or waiting until a female physician might come to their community. At present, provision of cervical cancer screening and other extended services by nurses occurs only in remote northern communities, where physicians are not available (Rennie, Baird-Crooks, Remus, & Engel, 2000). The women in this study had no experience with or access to this type of health care provision.

All of Canada, but especially rural, remote, and northern regions, are presently experiencing one of the most acute shortages in health care personnel in recent times. Rural, remote, and northern regions pose challenges, such as isolation and distance, which nurses and physicians can avoid during times of health personnel shortage by choosing to work in less isolated urban settings (Rennie, Baird-Crooks, Remus, & Engel, 2000). Thus, northern and other remote areas may experience particularly acute health personnel shortages. During the course of this study, Prince George newspapers almost daily included items addressing the acute shortage of health care personnel in the north. The numbers of health care providers, even in larger centers in the north, are extremely limited. This shortage presents women with particular challenges. For example, as a result of the nursing shortage, several hospital beds have been closed, and surgeries are often canceled in Prince George. Even health units, which traditionally have not had difficulty in recruiting public health nursing staff, have experienced acute shortages and difficulties in recruiting, especially in the more northern areas of the province such as Dawson Creek and Fort St. John (R. Hamilton, personal communication, February 11, 2001).

Quality of care

In addition to the decreased numbers of physicians and nurses, women also remarked on limited quality of care, which they related to *access issues* and to *physician attitudes and knowledge*. Quality of care related to access issues and physician attitudes and knowledge are problematic for women throughout Canada (Tudiver & Hall, 1996); however, in the north where women have limited choice of care providers, quality of care can be especially compromised.

Women spoke about limited access to care in terms of the time that physicians were available for seeing patients, especially the hours of service and the time devoted for each patient visit. Some small communities were limited in the availability of acute care services during the day and on weekends, as Barbara noted, “We still won’t have any weekend service with our doctors...[even though] we have two industries...(the sawmill and the mine) that run for 24 hours a day. And it’s [the mine] a big industry. It employs 300 people”. Rhoda noted that “It’s just the amount of time that they [physicians] spend with you - ten minutes at the most and you...have to take a list because I always feel that I’m being pushed out the door”. Barbara revealed the

9

comments that a neurologist made to her when she consulted him:

> "The government pays me to see eight patients a day and you're the twelfth"...like that's the first thing he says to me...I just didn't feel like I was...going to get any kind of quality check up or quality interview and he was very quick and very brusque with me.

Other women commented that some physicians would only address one of their issues in a clinic visit because physicians are remunerated for only one treatment issue per visit. As a result, women had to either reschedule visits to have all of their issues and questions attended to, prioritize their issues and forego having other health issues attended to, or forego seeing a physician altogether.

Quality of care for northern women was also compromised by the attitudes and knowledge of physicians. Some women felt that the quality of care that women receive from some northern male physicians is disrespectful and sometimes dangerous. Elizabeth described the brutality and insensitivity of care she received by a specialist in a northern community and her lack of ability to access quality care:

> That man was brutal but he was the only gynecologist...I just thought this man shouldn't even be a doctor and then he lost his license like two years later..He was bad, like rough, and he says to me, "Well, if you're going to have kids, you better have them now". And I said, "Well, I'm not into being a single parent..." [He says] "Well, what's the matter? Good looking girl like you, you should be able to go and find a man". I said, "Are you offering or what are you suggesting here?"...I would have asked to go somewhere else...but there was nowhere else to go...

Barbara provided a further example of the effect of gender on care received. She explained that she and a man in the community both had similar symptoms, yet were diagnosed differently by the same physician. The man was told immediately that he had had a stroke, but Barbara was not told anything. Rather, she was referred to several specialists and was not able to obtain a definitive diagnosis for several years. Barbara stated:

> ...you hate to think that you're down trodden but...a woman is rushed into an emergency room with chest pains, a man is rushed in beside her...she's got anxiety and he's having a heart attack...It's the kind of thinking that women bring on a lot of their own illnesses...that whatever a woman has that she's responsible for it directly...if a man has it...he's the bread winner...so he deserves to have [care].

Park noted that "sometimes doctors laugh about some of the things women will tell them". Rhoda believed that "Women [are] being objectified by physicians and hospitals and nurses and [are] not being treated as human beings and individuals."

These comments reflect the perspectives of several authors regarding gender and the marginalization of women's health care in general (Denton, Hajdukowski-Ahmed, O'Connor, Zeytinoglu, 1999; Sherwin et al., 1998; Walters, 1991). Women's quality care is compromised when their perspectives about their health are dismissed, and the knowledge they have about their illness is belittled or ignored. When the nature of women's lives is not taken into account when they see physicians, women receive care that does not fit with their values or their lifestyle. Indeed, women are often blamed for being ill, rather than treated with the care and respect that is accorded to their male counterparts.

Obviously, northern women are experiencing these types of gender biases and behaviors in their interactions with health care providers. This is particularly significant because northern women are imbedded in a northern context that undervalues women and their contributions and where health and other resources and supports are particularly limited. When resources are limited, it is particularly important that women have at least one place of refuge and respect - perhaps their physician - to turn to. Indeed, for some women, such as women in abusive relationships, extremely isolated women, and women from minority cultures that are marginalized themselves, a respectful interaction with a male physician may be their only or their primary source of support and self-esteem. If their physician simply reinforces male biased perspectives and stereotypes, northern women may have nowhere else to turn to access the care and support they need. As a consequence, these women are made especially vulnerable.

The quality of medical care available to northern women was sometimes compared to the care that is available to animals. Casey noted that when she needed intravenous (IV) treatment, she was sent home with an IV, whereas:

> When we take our animals in for veterinary care, they are more reluctant to let you self treat [the animals]...I actually think that our vet tracks the health of our animals more accurately than our own [health is tracked]...we don't get notices for pap smears but my cat when its vaccination's up gets a little postcard in the mail.

Vicki agreed that:

> As the person who owns the animal, I am afforded and can demand a great deal more courtesy from that vet...I'm in a position to say, No, I'm getting a second opinion, I'm going to evaluate your credentials before I trust my beloved animal to you...I am not afforded that kind of opportunity for myself.

Several explanations were offered for negative physician attitudes in the north. Some women felt that quality of care was influenced by the care provider's familiarity with and desire to be in the north. For example, Signe believed that physicians who were raised in the north appreciated northern culture and could relate to northerners. She described physicians who had been raised in the north as having "a free and easy way,...sort of easy to talk to - they're not some little tin god like some doctors here. [They] will discuss anything, you know." Christine felt that the provider's choice to be in the north was a significant factor in the quality of care provided:

> I know a lot of the social workers and nurses and doctors we have up here are wonderful people. And they come here by choice. But we also have a lot that are sent here to do their internship or whatever, and they hate it. And when you don't like where you are, you don't do a good job.

Others believed that physicians in the north did not adequately access continuing education to keep abreast of recent advances in care, and that continuing education could improve physicians' understanding, attitudes, and treatment of women's health issues. Rosie also felt that better communication skills would improve physician attitudes and patient care:

> To open up a dialogue is what the physician needs to do. Not just one sided, probing questions. The doctors I've met who do it [have open two way dialogues] are really well liked. And they seem to give better whole [holistic] patient care...[they ask] more social questions, not strictly [questions] about physical health. But they're [physicians] few and far between. The physicians I've had in my courses had the worst time with the communication component.

Physician attitudes may also compromise the quality of care that women receive from nurses, as Vicki explained:

> ...the doctors...have been strutting their stuff about how terribly terribly important they are to the system, you know, like 'next to God there's us and God relies on us too, you know'....I suspect that the doctors are depriving the nurses of their ability to be nurses because the nurses are picking up...the slack for the doctors...perhaps the nurses are being forced into more of a medical role than was traditionally theirs or maybe that they even wanted...I mean, the doctors go into a hissy fit and say, 'We're not being paid for so many days a year so we're just closing our offices'...Well, where do people who are sick go? They go to the hospital. Who do they see? They see the nurses.

In short, northern physician attitudes appear not only to compromise women's health directly but also to affect other aspects of the health care system, such as what and how nurses deliver services. For example, the shortage of physicians, coupled with their attitudes about the scope and type of care they will provide, creates a situation where nurses, as front line providers, feel compelled to assume tasks traditionally done by physicians. In small northern communities, where health care shortages are particularly acute, it is difficult for nurses, as community members, to stand by and refuse to assume additional duties, however inappropriate, when members of their communities need care. However, by "picking up the slack" to cover medical shortfalls and illness-oriented needs, nurses limit their ability to develop an expanded scope of nursing practice that would more effectively address the health care needs of northern women. Thus, physician attitudes compromise the ability of nurses to provide good nursing care and to expand the scope of nursing practice in ways that would make the best use of both nurses' and physicians' expertise.

Availability of hospital, diagnostic, and mental health services

In addition to limited options regarding the quality and availability of physician and nursing services, women noted that hospitals and other health care services are also limited in the north. Several women remarked upon the downsizing of their local hospitals, which some women viewed as a cost saving measure by the provincial government. Other women believed that the limited number of physicians contributed to this loss of service.

In this study, it was evident that the nature and degree of services women provided to others as a result of downsizing of care services resulted in significant burdens to women. Across Canada, the downsizing of hospitals and other services has affected health care in general and women's health in particular (Kaufert, 1996). Such downsizing shifts care from hospital to community and, since much of this care in the community and in the home is done by women, extra burdens are thus placed on women. Indeed, as Cohen and Sinding (1996, ¶ 53) aptly phrased it, "community based care can serve as a euphemism for unpaid caring labour by women, and government downsizing can be seen to both presume and coerce women's caring roles". In the north, few resources such as home nursing services exist to assist and support women when they are called upon to provide care in lieu of or to compensate for lack of hospitalization, particularly if women live outside of urban areas.

Specialized hospital services such as surgery and most diagnostic tests and services are also limited in the north. These services are only available in one location in the north, Prince George. Some services, such as medical resonance imaging (MRI) and, occasionally, mammography services are provided to northern communities by traveling vans. Other specialized diagnostic and treatment services, such as those for cancer, may only be available in southern locations. Signe expressed concern that the limited availability of medical equipment in the north compromised quality of care:

> We should have better medical equipment in the hospital...when my hip was broken, Dr. K. could have operated [in Prince George] if we had the equipment...why Prince George Regional Hospital is called a regional hospital, I don't know because they are sending people from here away to be treated 'cause they can't do it here [because of lack of equipment]...they [the government] can build these ferries worth two hundred million dollars and yet our doctors are leaving in droves because they don't have the equipment, they don't have the operating rooms - they leave.

Without adequate equipment, women must find the time and the funds to travel elsewhere for care, or they may receive limited or no care at all if they stay in the north.

Beyond the limitations for physical health care, women emphasized that mental health care is very limited in northern communities, as it is for women in the rest of Canada (Cohen & Sinding, 1996). Women in the north perceived that mental health care focuses on men's needs, favors drugs rather than counseling, and focuses less on mental health than on physical health. Professional counseling services are not readily available in small northern communities. For example, Christine described aspects of the service limitations for northern women with depression:

> There's more depression in women up here, than there is in men. And yet, from what I can see and from what I've heard, their [physicians'] solution is drugs, not necessarily counseling. And, without counseling, I would never have come out of my depression. I would never have learned to turn it around.

Moreover, some services are provided on a fee-for-service basis, which precludes their use by low income people.

In addition to limited professional mental health services, informal support available through mental health support groups is limited in small northern communities. Insufficient numbers of people with similar backgrounds or diagnoses in small communities may hinder the effectiveness of support groups. For example, Leah, who has been diagnosed with obsessive compulsive disorder, was looking forward to moving to Vancouver because there she could "find someone [who] has the same obsessive compulsive disorder [obsession with death] as me". Eileen, who is studying for a Master's degree, noted that "not a single person in that group is employed besides me. None of them to be blunt, is very high functioning...really I need a support group of people who are higher functioning. But it's so delicate to say...".

Maintaining confidentiality and anonymity in small communities is a significant problem for those accessing mental health services. Women with mental health needs may be stigmatized more readily in small communities where everyone knows everyone else and where associations are limited in scope. Marie, a woman who holds a public position and who has bipolar disorder, confessed that she could not participate in a local support group because she feared that her anonymity and confidentiality would be breached, and this breach would negatively affect her employment. Park elaborated further on anonymity and confidentiality issues regarding mental health services:

> I mean, if somebody's car was parked at the woman's center, people kind of assume that she's gone there to get help...When you're going to see a counselor [in a small community] you may be seeing her in other social functions as well...So women probably feel [that] their confidentiality is at stake...in bigger communities, nobody knows where you're going for help. It's easier for people to find out where you're going for help [in a small community].

Limitations in hospital, diagnostic, and mental health services for women in BC have been noted elsewhere and support the perspectives of the women in this study. In a study done by BC Women's Hospital (1995), the need for enriched physical and mental health services throughout the province was a key finding. Although northern communities received only limited attention in the study, issues related to geography, community dynamics, discrimination, barriers for women with disabilities, and hours of operation were identified as affecting women's access to appropriate health services. The BC Provincial Health Officer (1996) also has recognized the specialized health needs of women and, together with the BC Women's Hospital (1995), has concluded that services for women's health will be enhanced when women can access health services where they live, when quality interactions with physicians are *de rigor*, when women feel validated in the health care they receive, and when women are empowered to be responsible for their health.

Although the quantity, quality, and diversity of health care services are limited in the north, a few women did remark upon the exemplary care that they had received from physicians, nurses, and others. Christine stated, "I'm really lucky. I have a very good doctor. She's very caring - very - she'll listen to me no matter what I say. She may not agree with me....But she'll listen to me." Fred appreciated the multiple sclerosis clinic that was recently established in Prince George because in each visit to the clinic she could see a variety of care providers such as "the neurologist, a nurse, an occupational therapist, a physiotherapist, and a social worker", and she no longer needed to travel to Vancouver for services. Women also appreciated care providers who were honest and open, who respected them as partners in their health care, who used holistic approaches, who readily admitted limitations and referred them to appropriate others, and who were not averse to women's use of alternative therapies.

Accessibility of alternative health care services

Congruent with Canadian women's perspectives generally (Tudiver & Hall, 1996), women in this study valued alternative health care services and therapies that complement or substitute for traditional health care. Increasingly, women and health care professionals throughout the country - including the north - are demanding information about and using alternative health care (Tudiver & Hall). Some of the services and therapies that women in this study valued included massage therapy, healing touch, acupuncture, chiropractic services, midwifery, doulah services, naturopathic services, iridology, aromatherapy, and herbal remedies. If women had access to these types of services, they used them as their sole source of health care, or in addition to treatment by physicians.

As valued as alternative health care services were, they are not readily available to women in isolated settings. Barbara summarized the sentiments of several women in the study when she stated, "I just wish there was somebody that we could access locally". Alternative health care services either do not exist or are offered sporadically in small communities, probably largely due to the sparse populations and the subsequent inability of alternative health care providers to secure adequate incomes from their health practices. Thus, women from small communities must travel to obtain alternative health care. For example, Margaret travels to Vancouver for acupuncture treatments "once a year...This [travel] comes from my own money but I wouldn't go without it". However, the costs of travel to distant communities for care are prohibitive for many northern women. It must be noted that the lack of availability of alternative health care for northern women, and the reasons for this lack of availability, are quite probably reflected in the experiences of other women in Canada who live in isolated settings.

Even if alternative health care services were available locally, some women would not be able to afford to pay for these services. For example, Linda, a woman living on a low income who is unable to work because of fibromyalgia, benefits greatly from massage therapy and herbal remedies. However, these therapies are not included in the provincial health insurance coverage and, because Linda cannot afford to pay for these services herself, she must forego massages and endure increased discomfort:

> I want free massage. If you have a health condition that warrants it, then you [should be able to] have a referral, [and] have it done. You shouldn't have to pay extra for that. If you have a broken leg, you get a cast and it doesn't cost you anything. But for this (fibromyalgia), I just feel like I'm going to have to suffer forever because I can't afford to buy the things like herbal remedies that might help me get better. And I can't work because I'm in pain. It's a vicious circle...It frustrates me.

Signe, an elderly woman living on a low income, is not able to pay for alternative therapies "because I get a pension and if I have to pay for it [alternative therapies]- [it means] no groceries - so I make do as best I can". Alice also noted that the costs of alternative therapies, however desirable, are prohibitive for her, "I like the idea of herbal medicine, alternative medicine. I do look into it. But [when] you have to start paying for services and medications, then you need quite a bit of money [and] I'm not in that situation". Thus, for women living on low incomes, access to alternative health care services and therapies is compromised.

Some women noted reluctance on the part of their physicians in recommending the use of alternative therapies. Physicians and their associations in North America have historically excluded alternative health care from their practices and recommendations and have relegated them to the margins (Tudiver & Hall, 1996). Jocelyn summarized what several women in the study noted, when she stated that she "would like a more open mind to alternative therapies" on the part of physicians. Although physicians' attitudes towards alternative therapies did not deter women from learning about and accessing these therapies, the women would have preferred that their physicians endorse and legitimize alternative therapies. For example, Christine appreciated that her physician "told me [about] people to see about different holistic medicines and things like that." Marie valued her physician's support, "his helping me - and I underline helping me - do what I could to be responsible and knowledgeable regarding my own body, health, mind, emotions."

Lack of access to naturopaths and other alternative health care providers in the north limits women's abilities to access information and to make informed decisions about alternative health care. As a consequence, some women turned to nurses for advice. Alice noted that "you can go to the health unit...the public health nurses really open their doors". However, if physicians, nurses, and naturopaths are not available to provide information, discussion, and advice, women's abilities to make informed decisions about alternative therapies are compromised. As Barbara explained, "There's so much to read...you have to do your own homework [and] you don't know how to weed it out". In the north, where health services of all types are limited, it behooves women and their health care providers to make the best use of all of the services that are available, including alternative health care services and therapies. Increased access to knowledgeable health care providers would facilitate northern women's abilities to effectively and safely use alternative health care services and therapies.

Health Promotion and Disease Prevention Services

Health promotion and disease prevention services, too, are very limited in the north. Services commonly identified as limited were *health education, parenting support, relationship support, school health,* and *social services*.

Health education

Health education is very important for northern women because of the limited medical care services. Lack of access to nurses, physicians, alternative health care providers, and other sources of health information and treatment requires that women try to prevent health problems and learn to take care of their health. As Amelia explained:

> I believe that it really behooves us all to take care of our health, not to let it deteriorate...because you don't have a doctor that's right there...and besides, they don't have all the answers. So I think it's good to practice preventive health care.

Women in the study wanted information about many and diverse aspects of illness and health. For example, women wanted information about diseases such as multiple sclerosis, cardiac conditions, asthma, arthritis, allergies, and mental health conditions. They also wanted information about normal aging processes, including menopause. Information about ways to stay healthy and to prevent health problems was highly prized. For example, information sessions about ways to prevent and alleviate problems related to menopause were very well attended in northern communities. In addition, because of the isolated nature of northern communities, women wanted first aid and treatment information so that they could look after themselves and others in remote areas. For example, Elizabeth needed to know how to suture a nephew's wound when she lived in a very remote area where physicians and nurses were not available. Indeed, the women in the study were keenly interested in any information that would help them stay healthy and regain health should they or others become ill.

However, women's health education has been neglected and is difficult to access in many northern communities. The reasons for this neglect and limited access articulated by the women in this study are related to the *northern physical and psychosocial environments, health care providers' limited knowledge*, and the *attitudes and skills of women and health care providers*.

The northern physical environment presents challenges for health education. Distance, weather, and road conditions can compromise travel to health education programs, which are usually located in larger urban centers, if they are available at all. Jocelyn noted that "there are a lot of women who don't have transportation or who don't have the money to go", and Barbara stated that "we just don't get to things in bigger centers...I'm not fond of winter driving so that really limits me". Traveling at night was also challenging for some women due to winter weather and road conditions, and the presence of wild life on the road. Thus, for safety and financial reasons, some women would not be able to attend health education programs.

The northern psychosocial environment also influences the availability of women's health education. In the north, health care often reflects male-dominated priorities. The health education needs of women often take a back seat to the needs of resource-based industries. For example, Barbara noted that physicians were needed in her community because "we have two industries, the sawmill... and the mine". Limited health education may also be related to northern women's limited power, knowledge, and expectations, as Rhoda alluded to in her comments about how she improved her health situation:

> I think women are starting to take their power back and stand up for themselves more...If I'd accepted their criteria, I would still be with my other doctor. But I know what my rights are and I have the right to pick and choose [my physician]...I want to know what the possibilities [for menopause treatment] are - I want to know. And we all want to know.

Thus, attitudes towards women by both women and men affect the resources that are provided for women's health needs, including health education.

Limited health education opportunities also were perceived to be due to health care providers' limited knowledge. Amelia explained, "I think maybe educating our doctors in ways of health, rather than so much - well, of course, it's important to fix things when they go wrong, too, but preventive medicine is, I think, important." Amelia suggested that more education would also improve physicians' "attitude[s] towards natural things", and would increase physicians' respect for women. Increased respect for women, it was hoped, would decrease physician dismissiveness of women's requests for information and their desire to be actively involved in their health care. Thus, increased education for health care providers can improve health care by and for women.

Women's own attitudes and skills may hinder their abilities to access education from health care providers. Rosie, a nurse, noted, "I've had lots of clients say to me, 'Well, I can tell you what's wrong, but I can't tell the doctor'". More effective communication skills of both health care providers and clients would facilitate open discussion and information sharing. Rosie stated, "The women that come in [to the physician] have poor communication and assertiveness skills. They have a very vague idea of what bothers them, but they can't be specific about it". On the other hand, Rosie also noted that "physicians ask closed questions...doctors [need] to ask open ended questions, ask more social questions, take more time,...develop skills in listening". Health education would be enhanced if physicians encouraged openness and respect in their interactions with women patients. Some women remarked that older physicians tend to be less open to women's perspectives, and physicians from other cultures may perceive women in a more subservient role. Vicki stated, "as the older doctors retire, hopefully the next generation of doctors will be the ones that have come up with the more open modern outlook towards women."

Paternalistic attitudes that allege that women are subordinate to men, and that being rugged and self-reliant means that one takes care of oneself may discourage women from seeking help from others, especially from outsiders to the community such as health care providers (Bailey, 1998; Chafey, Sullivan, & Shannon, 1998).

Indeed, Rosie noted, "In most rural communities and with a lot of old timers in the north, it's like '[Go to the] doctor? No. I haven't broken my leg'....It has to be really severe before they go". This reluctance of women to see a physician may be accentuated when health care providers are men, as is the case with most physicians in northern BC, and when paternalistic attitudes and self-reliance are highly prized and prevalent, as in northern BC. In such a context, access to health education would be enhanced if there were more female health care providers, as Rosie explained, "If they know you're a nurse, up comes all these questions...Nurses are deemed approachable, they're women. Even real macho men [think] it's okay [to talk to a nurse]".

In summary, women in the study believed that improved access to health education was important to empower them to take care of themselves and others in sickness and in health. In addition, the women hoped that increased health education to women and to health care providers, especially physicians, would help women receive more respectful and up to date information and services. At present, however, the lack of access to health education contributes to northern women's decreased ability to be involved in their health care in an informed way, and, as such, contributes to their marginalization by limiting their options.

Parenting support

Limited options exist in providing support for parenting in northern communities. The lack of support for parenting is related to values attributed to women and women's roles.

The undervaluing of women's roles as mothers is highlighted by the deficient day care services in most northern communities. Linda, a mother of three children, is unable to find affordable day care and, as a result, her ability to obtain employment is limited. Park suggested that day care programs are especially important for teen mothers and single parents "because we don't have the same kind of family supports as we did before". In the north, lack of family support can be especially problematic because young families often come north for employment, leaving family and friends behind. Park noted that without the "backup" of grandparents or marital partners, "it makes it more difficult for you to continue with your dreams or your careers."

Information and support groups that facilitate anticipatory guidance and problem solving are also limited. Eileen noted that "the only courses there really have been for parenting in the seven years I've been here have been aimed at people who are having trouble." She wanted to go to parenting classes "not because there was something wrong but because it's [parenting] a very complex job and it's always changing." Eileen speculated that the lack of support for parenting may be related to values attributed to women's roles:

> I don't think mothering is respected very much...I noticed a lack of respect for me as a mother and as a thinking person, particularly by men in the community...I think it's because a lot of women here still struggle to respect themselves as mothers.

Thus, the decreased value attributed to women's roles may result in lack of resources for parenting in the north.

The traditional roles of women as housewives and mothers have been presupposed and desired for northern communities (Gill, 1982; Wall, 1993). Women have been viewed in northern communities as providers of support, nurture, and care to their families, yet they "have rarely been recognized as individuals responsible for their own...well-being" (Wall, p. 44). However, the 'new woman' in today's society desires respect for her roles both within and outside the home. Lack of respect and support for these roles leads to stress (Barnett, 1993) and ill health for women and their families (Kelleher, Rickert, Hardin, Pope, & Farmer, 1992). Rural and northern women may be especially at risk for emotional stress because their changing roles present a challenge to traditional rural and northern life as these women struggle to meet their now conflicting roles of worker, wife, mother, and household manager (Bigbee, 1984; Mansfield, Preston, Crawford, 1988). Lack of respect for women in these roles coupled with decreased support for parenting can only increase northern women's risk for ill health. On the other hand, support for parenting and sharing of parental roles can decrease stress and result in better health (Barnett; Bigbee), more health promoting behaviors, and higher self-esteem (Woods, Lentz, & Mitchell, 1993), particularly for women in rural and northern settings (Mansfield, Preston, Crawford; Wall). Limited access to parenting support, therefore, results in limited access to health.

Relationship support

Women perceived that inadequate services exist to promote and support heterosexual and same sex relationships for women in northern communities.

For women in heterosexual relationships, support for those relationships, especially in times of stress or separation, is limited in small communities. Eileen noted that when she and her husband were having marital difficulties, it was difficult to find family therapy services:

> It was very frustrating....there were no services that were oriented towards the whole family...there was nothing that looked at treating the family as an organic whole. It was all aimed at separating everybody off. Dividing you up. And I'm still upset when I talk about it four years later.

The lack of professional services is made more salient because there may be less informal support. Eileen found limited support from friends during her separation from her husband. She felt betrayed by this lack of support, but offered some insight into this situation:

> [I felt that my friends were] very afraid it [their support] will affect them...socially but economically as well...life can be made quite difficult for you by the alliances about the town. That's if they're against you, if you're on the wrong side. I think people dance much more lightly here.

Women in same-sex relationships also may experience inadequate support and services. Although no woman in the study identified herself as lesbian, Park talked about the isolation and withdrawal experienced by homosexual people in her community, "It's a human being's desire to be loved and accepted in society. If you're not, your actions are going to be controlled and you're not going to participate as much as you would like. I think it's hard to reach your full potential when people are judged".

Other research that investigated the health of lesbian women in northern BC (Anderson et al., 2000) also highlighted the isolation of northern lesbian women, and identified lack of services for these women. Even if services and activities are available in a northern community, some lesbian women may choose not to participate for fear of being identified as lesbian. In addition, lesbian women may choose to live with partners secretly, hide their lifestyles from others, or deny their lifestyles as ways to protect themselves and promote access to health care and other resources. Therefore, lesbian women whose lifestyles are different from the mainstream heterosexual relationship with children are likely to experience more restricted and less appropriate access to whatever activities and health promoting options exist in small northern communities. By being denied access to these options, lesbian women are excluded from activities that help promote and sustain healthy relationships and that would help them feel accepted as fully contributing and valued members of their communities.

Certain groups of women may be more marginalized than others in terms of their options for accessing health promotion activities that support relationships. Single women of all ages often experience life at the periphery in northern communities. Leah, a young woman of 21 years, noted that "[my community] is very couples oriented...there's not a lot of single women my age for me to hang out with and like, most of my friends are all...older and...married". Marie noted that educational and recreational opportunities, such as ballroom dancing lessons, are more limited for single women because small communities tend to be couples-oriented. Signe commented on the isolation and loneliness of some single female senior citizens, of their desperation to see "a friendly face...There's got to be something out there [for them]." Although activities that promote health may be available, these activities may be reserved for women who fit the community norms regarding relationships.

From the comments of these women, it is clear that more support for women's relationships is needed in northern communities. More support for marital partners and families, and more support to enhance diverse women's relationships would decrease the isolation and exclusion that some northern women endure, and would increase their acceptance and inclusion as valued members of northern communities.

School health

Although the focus of this study is on the health of women aged 20 years and older, two young women in the study, Leah and Ruhi, spoke at length and with emphasis about health issues they recently experienced as teenagers during their high school years in the north. One of the issues these women identified was the need for enriched counseling services in schools. These women believed that counselors and psychologists are needed in schools to help teenagers who are feeling isolated or who don't feel as if they "fit in". Leah described her experience of being a high school student three years ago in a northern community, "I just didn't fit in, it was miserable for me those few years. And like the counselors, they teach gym [rather than do counseling]...that's hard to go there every day, like I would fake sick...I dreaded going to school." Given the high incidence of school dropout in northern communities (Report of the Northern and Rural Health Task Force, 1995), high quality school counseling services could help northern students stay in school and complete their education. Counseling would help students suffering from mental health problems, students who are struggling academically, students who are exploring lesbian or gay sexualities, and students who live in particularly trying family situations.

Another health problem in schools is substance abuse. Ruhi noted that when she was in a northern high school two years ago, "half the students smoked" and "people brought drugs to school to sell to the kids". Alcohol abuse was also common at her high school. Ruhi noted that "my friend - his mom buys alcohol for him...older people [such as parents] should understand that they shouldn't be selling drugs and smokes and booze to teenagers". Enhanced education and counseling about substance abuse in northern schools for students and parents would help students and their parents learn about healthier ways of coping with life stresses. Such education and counseling would improve student and parental health in the short term and the long term, as parents are helped to cope more effectively, and students learn healthy ways of coping before substance dependency is chosen or becomes entrenched.

Social services

Women's resource centers, women's shelters, and services provided by social workers and the police may be very limited in terms of their quantity, quality, and diversity in small communities. Park, a woman who works at a women's resource center, noted the lack of funding that restricts services the center can offer:

> We have one full time counselor position - it's not for the full year and it's a contract position. We could use another half time position [and both positions] should be for the full year. There's not enough [funding]. It took us 10-12 years to get the sexual abuse counseling programs [funded]. Over 100 new women every year come for one-to-one counseling, a high percentage for sexual abuse counseling.

Often, even if services are available, they may not be accessible due to location, hours of operation, and cost of the service. For example, a service may only be offered on an ad hoc basis or by personnel who visit a community only periodically. In addition, a service may be located in a remote part of the community or in another community, which requires transportation, and there may be a charge for the service.

Services may also be limited by distrust. Mary, a social worker with Aboriginal people, noted that distrust on the part of her clients as well as herself may hinder women's abilities to access effective police services:

> I say [to clients], "This is how you should do it [report abuse], even though the RCMP might [have been] untrusting to you in things that have happened in past situations, there is a purpose for them here"...So sometimes they [clients] follow through, and the organizations haven't quite lived up to...how they should be helping, sometimes they don't [help]...I guess I should go down [to the RCMP] with the women, but I haven't gone yet. I don't know whether I'm distrusting of them as well...

Thus, attitudes of distrust and possible discrimination serve to keep women in unhealthy marginal situations.

Other Services and Resources

Northern women are often limited in their access to other services and resources that enhance their health and quality of life. These services include *arts and recreation* and *technology*.

Arts and recreation

Arts and recreation services were important to women because they contributed to women's ways of achieving health and staying healthy. The women in this study defined health holistically, as "the combination between the physical health, spiritual health, and psychological health", as Alice explained. Physical and mental health were both highly prized and seen as interdependent. Barbara noted, "Health means a state of mind...whatever will happen to your exterior [physical] body, it's where you're sort of at in your mental body that can make you better". Happiness was seen as important for health, as Carmen stated, "If you're happy, you're probably going to be a whole lot healthier". Lillian felt that "when you're feeling contented and happy, not miserable and depressed" you are mentally healthy. Signe knew she was healthy when, after an illness, she was able to laugh again, "I was watching that British comedy Are You Being Served? And I laughed out loud. And I thought, 'I'm better'. I knew I was better because I laughed out loud". In order to achieve and maintain health in the holistic way that they defined it, the women in the study valued being able to access arts and recreation resources that they enjoyed.

However, arts and recreation resources are limited in the north. Restaurants, art galleries, music events, swimming pools, and other arts and recreation resources either do not exist or exist on a limited basis, as these comments indicate:

> I feel like seven years behind culturally since I moved here. (Eileen)
>
> We don't have a movie theater. (Barbara)
>
> We get some things but they are on a much smaller scale. (Carmen)
>
> The opera comes through once a year. (Elizabeth)
>
> I get depressed when I can't have ballet. Where's the ballet? Give me a dance company here. (Jocelyn)

> We won't go to the pool...a lot of people have ended up with different things [illnesses & infections] from that pool. (Linda)
>
> We need a bigger real pool. (Casey)

Casey and Linda summed up the sentiments of several women in the study regarding the limitations in arts and recreation resources when they said: "You don't [have] what you would if you lived in a larger center. So far as facilities being available [here], they're not really there" (Casey); "We find if real difficult to find things to do here, entertainment wise. Other than just the outdoors" (Linda).

Even if resources are available, the physical environment can hinder women's ability to access them, as Christine explained, "There's [cultural] things here. It's getting people out to them. In the winter, it's because of poor conditions for driving. A lot of people live in the outlying area, and it can be hard to get into town". In addition, the time and finances needed to travel long distances to arts and recreation resources and events can preclude women's participation.

Women's inability to access arts and recreation resources limits women's choices. For example, Eileen noted that without a book club similar to the one she enjoyed in her previous community, "Life here feels very constrained in terms of not having like minds". If women are limited in being able to enjoy the arts and recreation they prefer, they can learn to live without the missing arts and recreation, or they may choose, and hopefully learn to like, activities that are available. As Lilac advised, " If you choose to live here, then you adapt - you put up or make allowances for the lifestyle". For example, although Casey enjoys swimming, because of the poor swimming facilities, she has decided to choose physical activities such as running that she can do on her own, without depending on other resources. Thus, northern women must rely more on their own resources or learn to do with less or without when it comes to the arts and recreation. This may compromise northern women's ways of achieving health and staying healthy.

Technology

Technology can be defined as the tools, techniques, and the art and skill of people in the application of tools and techniques (Wajcman, 1991). In this study, limited technology options were available related to *transportation, telephones*, and *computers*.

The physical environment influenced options for transportation. Although most women in this study owned and could drive a vehicle, winter weather, distance, and night time posed hazards for women. Lilac, an older woman who has lived all her life in the north, noted that she will not drive long distances alone, "I'll drive one way and my daughter will drive the other. If it's night, I certainly wouldn't go". Women who did travel in wintery weather and over long distances were more inclined to own vehicles suited to those climates and terrains, such as trucks and four wheel drives. For example, Jocelyn explained how she ensures that travel from her country home is safe:

> I opted for the new vehicle with a warranty so that if anything went wrong, everything would be covered. The down side of that was that, although I had a new four wheel drive which is very reliable and nice and fits me, the cost was exorbitant.

Thus, women could travel more readily if they had the finances to buy suitable vehicles. Often the vehicles that are best suited to the challenging physical environments of the north - such as four wheel drives and trucks - are more costly to purchase and maintain than vehicles that would be suitable in less challenging environments. Depending on others to drive one's vehicle or traveling with others limits women's independence, options, and privacy regarding where and when they would like to travel.

Lack of public transportation such as buses and taxis in small communities complicates or prevents northern women's abilities to access services. When urban bus service is available in northern communities, the hours and frequency of operation are usually limited. For example, city bus services in Prince George, the largest northern city, do not exist on Sundays and are very limited in the evenings. Bus service to communities within and outside of the north is also very limited. Most northern communities do not have taxi services and, if such services exist, they can be quite costly, especially for long distance travel. Thus, limited access to public transportation compromises women's ability to access resources in effective and efficient ways, and contributes to women's geographical marginalization.

Telephone technology is generally available to most women in the north. However, some women do not have telephones. Gert stated, " If you're trying to reach Aboriginal women in some of the villages, not everybody has a phone". Because of their remote location, women such as Rosie may need to install a special type of telephone, often at their own expense. Even then, these telephones are not always reliable, especially in stormy weather.

The technology of telephones helps reduce women's loneliness and isolation and frees their time from unnecessary travel. Ongoing telephone communication between female family members is an important part of their support and contributes to women's sense of well-being, security, stability, and self-esteem (Wajcman, 1991). Wajcman contends that by increasing women's access to each other and the outside world, the telephone has improved the quality of women's lives more than any other domestic technologies. This is particularly so in the north where women may live far away from friends and family. In addition, the telephone is important for safety reasons. For example, Casey noted that cell phones make travel in remote areas safer. Thus, northern women who do not have telephones or who have limited access to reliable telephone service are at greater risk of isolation, limited sense of well-being and security, and limited effectiveness in making appointments and travel arrangements.

Northern women are often compromised in their access to computer technology and are therefore isolated from information and supports that computers afford. Those northern women who do not have telephone or cable access are unable to access Internet and email services. Some women, such as Signe, an older woman living on a low income, are unable to afford computers. In addition, future generations of northern women may not be interested in or facile with computers because of gender discrimination experienced in schools. Marie, a teacher in a northern elementary school, explained why this discrimination is happening:

> There's free computer time at lunch time. Why don't the girls use the computers? It's because the games and things they play on computers are designed with boys in mind. Also, girls find it difficult to fight off the boys. The boys make this mad dash and they're overpowering. Even though the girls are smarter, often they're insecure.

Wajcman (1991) noted that the aggressive behaviors of male children and the expectation in families, schools, and societies that computers are male technologies discourage female access to and use of computers. Thus, attitudes in the north that privilege male priorities and needs may contribute to decreased access by female children and women to computer and other technology.

In the north, where information and services are at a premium, women who can access their own resources, such as information on computers, are empowered to make health care decisions in a more independent and informed manner. In addition, the computer can provide social support through email and other communication programs. However, women such as the elderly, or physically disabled, or low income women who cannot access computer technology are denied this information and support, and are dependent on limited local resources. If northern female children are not supported in their access to computer technology, future generations of northern women may continue to be compromised in their ability to access this important technology .

Education

The women in this study described limited options with respect to the quantity, quality, and diversity of education available in the north. To appreciate their concerns, it is important to convey their beliefs about the *value of education* and the *sources of education.*

The Value of Education

Women in this study highly prized education; its importance was remarked upon by almost every women in the study. Yet women felt marginalized in their ability to access education. They valued education for its importance in increasing their abilities to be responsible for their health. Because of the lack of health care and other services in the north, women felt more responsibility for their lives and their health. Elizabeth recommended, “Make information available because, unless you can suddenly drop a lot of specialists and doctors into these communities, women have to have the information to be responsible for themselves.” In addition, they valued the contributions that educational courses would have for women’s self-esteem and sense of agency, which would assist them to acquire the knowledge and abilities to make changes in their lives. For example, education can empower people to ask questions of physicians and make health changes that prevent or alleviate illness. Being empowered to make changes may be especially important for women in low socioeconomic situations, as Mary explained:

> I work with [women who have] a very low income...and a lot of them want to just be able to take a course...just to feel good that they can do something...you know, cause, if they can do one course, maybe they can do this and, you know, [it] branches off from there.

However, Mary also noted that there are “more and more wait lists” for training for women from lower socioeconomic backgrounds, and particularly for Aboriginal women:

> ...sometimes these women only have this little opportunity or window...and when that closes, then...it’s closed for a long time...They’re ordinary people that deal with a lot of discouragement and just more [inconvenience, such as wait lists] is going to just discourage them [further] and pretty soon they’ll say, “I’m not going to bother”. So I think there has to be more openings where they can get in and begin to feel like they are... better[ing] themselves.

Rhoda, a woman who works in a transition house for women, agreed that education can help women improve their situations. However, she admitted that the staff at transition houses and counseling agencies themselves require additional education if they are to provide adequate education and support to others. Limited educational options can therefore contribute to women's marginalization in terms of their access to further education, employment, self-esteem, agency, and empowerment.

Several women in the study perceived that women are still seen as the primary care givers for families and communities, and that education can help them in these roles. Rosie explained how women's education can affect the women, their families, and their communities:

> [Women] seem to do the bulk of that type of work [child development and family health]. And often, I found, the woman is the one who changes the family internally. And she may not make an attempt to change her kids or her spouse, but she changes herself and, in turn, there's a ripple effect on the family unit and the community...a woman should be able to have access to that information and...help...and the feedback she needs, you know, to just manage things.

Lilac agreed about the importance of education for women and their families, "*I really do feel strongly* [her emphasis]...I mean...a woman needs an education...you educate a boy you educate a man, you educate a girl, you educate a family".

From these and other women's comments, it is evident that education is very important in helping women to advance health care for themselves and their families, and to enhance self-esteem and agency. Without education, northern women are compromised in their ability to become and stay physically and psychologically healthy.

Sources of Education

Northern women experience limited options in sources of formal education such as universities, and in informal educational sources such as public libraries. Several women remarked upon the importance of access to a university for northern people. For example, Rhoda focused on enhanced employment options that can result from a university education, "...that's [university education] something that was never available here before. I think that you were expected to follow your father's footsteps and go into the mill. Now you have options". An indication of the value northerners placed on having a university in the north is revealed by the fact that, for ten years prior to 1994, people throughout northern BC actively lobbied politicians and donated money to facilitate the construction of a university in the north. Several women in the study identified themselves as donors and early supporters of the University of Northern British Columbia (UNBC).

Education at the university level has historically been virtually inaccessible for many northern people. To access university education, most northern students needed to move out of the north, a move that may not be financially and culturally possible for many northern students. For example, students from small northern towns or First Nations communities find a move to a large city in the south to be expensive, and a considerable culture shock compared to their familiar surroundings. However, the opening of the University of Northern British Columbia in Prince George in 1994 increased access to university education for many northerners, including several women in this study. Although UNBC has satellite campuses throughout the north, access to a full complement of university courses, programs, and degrees is still limited largely to Prince George. Therefore, for women who live outside of Prince George, access to university education remains problematic.

Some women expressed the view that education in a formal setting, such as a university or community college, can facilitate personal and community interaction and appreciations. Robin noted that men in resource-based jobs are used to engaging in physical types of work which are rewarded with “good wages” and which predispose men to “settle arguments physically.” Robin believed that education can help people “interact more appropriately with people...to think out something”, rather than to react in a physical manner. On a broader canvas, Robin believed that education, such as that provided by a university, can facilitate greater appreciation of cultural values and amenities:

> Because of the university and because of these influx[es] from other more civilized areas, we’re seeing changes...the university has made a big difference. [Prince George has] that beautiful theater now and the art gallery...it’s like

> we're getting people in [such as faculty] who aren't just gone to grade twelve...or grade ten and gone into the mill.

According to these perspectives, formal education, such as that at a university, exposes individuals and communities to other ways of being and seeing the world, which can lead to richer and more meaningful lives. For example, faculty at UNBC are from all over the world. These faculty bring with them experiences, ideas, values, and expectations that exist only marginally in Prince George. Consequently, and as Robin's remarks above indicate, this influx of faculty from outside the north has created a shift in how the community sees and constructs itself. However, as previously noted, access to university and other education in northern communities, although improved, remains problematic for many women and men, both resident in and outside of Prince George.

Traditional conservative attitudes about gender roles and about life circumstances such as employment prevail in many northern families and communities, and these attitudes may hinder women's and men's valuing and utilizing university and other formal education. Lilac noted that a gender-stereotyping attitude "exists everywhere they get away with it. And yes, there are still people raising their daughters to get through high school and either get married or find a job." Some women also suggested that northern men may not be as receptive to education and change as northern women. The resource-based economies of the north often provide young men with relatively easy access to high paying jobs upon graduation from high school. As a result, these men may not see the importance of education beyond high school, as Rhoda explained, "...these kids are coming out of school and going right into the mill and making big bucks and not thinking that it's ever going to end." Eileen elaborated on how limited education and life experiences may result in a narrower view of life:

> If they [men] do graduate from high school, I think that helps...The more education they get. And the more travel and exposure they get...I think part of it [traditional attitudes and behaviors] is they're stuck here...They just haven't been exposed to very much at all.... they lead narrow lives...

The existence of the University of Northern British Columbia in the north will help to address attitudes and lack of educational opportunities that northerners have historically experienced, and which have contributed to their marginalization.

Although formal education such as that offered by universities and community colleges was valued by the women in the study, women also valued education acquired in more informal ways. However, women's access to informal education is also limited in northern communities. Public libraries provide access to some information in small communities, although selection may be limited, and they offer satellite branches and inter-library loans which enhance access to information in rural communities. However, the politics of funding for these services seems to be an ongoing problem. It is noteworthy that funding does not appear to be problematic in several northern communities for the construction of large arenas for rodeos and hockey - recreational activities dominated by men. Although more affordable satellite dishes are facilitating distance learning and Internet access, as has been discussed previously, access to computers, the Internet, satellite dishes, and other technology is limited to those women who have resources such as the funds, the technology (electricity and telephone services), and the interest to purchase and engage in these sources of education.

To summarize this section on limited options, marginalization in the north is characterized by limited options of resources such as goods, services, and education. These resources are limited in terms of their quantity, quality, and diversity, and, as such, have an enormous impact on the health and quality of life of northern women.

Limited Power

Aspects of power were addressed directly only minimally by the women in the study. However, indirect information provided by the women, such as their descriptions of their agency and activities, as well as data from my observations and the literature help articulate important issues of power experienced by marginalized northern women. In particular, northern women experience power delimited by geography and gender.

Power Delimited by Geography and Gender

Northern regions in Canada have been marginalized and experience limited power (Coates & Morrison, 1992; Delaney, Brownlee, & Zapf, 1996; Southcott, 1993). The northern regions of the provinces lack a large and concentrated population base and the political influence or economic resources to investigate their problems and solutions (Coates & Morrison). Northern regions hold much of Canada's resource-based wealth (and hence a good measure of its economic future), yet many of the country's poorest and most disadvantaged citizens (such as Aboriginal people) live there, and the area has virtually no national voice or constituency (Coates & Morrison). Although much of Canada's wealth originates in the natural resources in the north, decisions about the extraction of these resources are made in southern urban regions, with little input from northerners themselves. Exploitation, oppression (Arges & Delaney, 1996), futility, frustration, dependency (Weller, 1993), underdevelopment, and impoverishment (Coates & Morrison) remain principal characteristics of Canada's provincial norths.

Within this northern context, many women's lives are linked to economic dependence on men who are employed in the resource industries. This limits women's power. Several women in this study remarked on the dependence they feel as a result of their husband's employment. Linda and Carmen both have husbands who work in the mining industry, which, at the time of this study, was experiencing a downturn with subsequent layoffs. Carmen remarked on the frustration she experienced when her husband was laid off, resulting in the loss of a substantial stable income and to significant changes in lifestyle and future life planning. Carmen and her husband, who are in their 50s, eventually moved to another northern community where Carmen's husband found work in another mine. Moves to ensure her husband's employment were viewed as compromising Carmen's own choices in life because, rather than moving further south as she desired, they were required to move whenever and wherever resource-based jobs existed, which is in the north. In addition, constantly moving for jobs entailed loss of equity in property and costs associated with moving. Moreover, for people in their fifties, financial losses and insecurities are particularly hard to take because options for retirement become compromised. In addition, the contract basis of much of the employment in resource-based industries decreases the ability of employees and their families to plan for the future. Because of downsizing and threats of industry closure, employment is often not secure or long term.

These experiences indicate the uncertainty and lack of control that some women experience in gendered economic environments. Marie noted that women's dependence on the resource-based sector of the economy may compel them to put up with gender inequities to sustain employment for their husbands, "If you're blatant about it [feminism] and open about it, it's not really good, because...it's the acceptance factor. You might be ostracized or not accepted". In a small community with few jobs, non-acceptance could cost one's livelihood. Thus, women may be especially reluctant to exert control when there is a downturn in the economy and jobs are at risk.

Beyond their dependence on their husband's employment in resource-based economies, some women noted that their economic exclusion is fostered by the assumption that housewives and mothers do not need to be responsible for their own economic well-being and that women's primary responsibility is to home and family. In addition, few well paying and satisfying job options exist for women in the north, and there is limited access to education that would facilitate the acquisition of well paying and satisfying employment. As previously discussed in this chapter and in The Northern Context chapter, women in this study experienced limited options in and often exclusion from equitable access to education and employment. Thus, northern women are often denied information and finances, the tools needed to acquire and maintain power.

Some women noted that religious beliefs may foster traditional attitudes that further compromise women's power and opportunities. Leah perceived that "a large religious population here...probably contributes to the lack of opportunity for women" because traditional beliefs are fostered. Some of these beliefs include, "men are the bread winners, women belong at home raising the children". Marie also believed that while the church fosters a sense of community, it may also result in rigidity of values, whereby people become "so dogmatic...they don't want to actively listen and even consider the possibility that there could be other answers".

Decreased power that results from religious and male values was most noted by women in the study who had advanced university education and life experience outside the north. In addition, older single women such as Marie and Signe also spoke about male and religious values and their effects on women's power and women's marginalization. It may well be that women who learn about other ways of being and who have independent life experiences may be better able to locate northern women's power in the structures of their communities.

The views of limited power expressed by the women in this study are congruent with the concept of power articulated by Hall, Stevens, and Meleis (1994). Within the context of marginalization, Hall, Stevens, and Meleis define power as "influence exerted by those at the center of a community over the periphery and vice versa" (p. 27). According to these authors, the margins experience influence from the center in the forms of authority and control, whereas innovation and resistance originate from the margins to affect the center. Those at the periphery - the marginalized - depend on technologic and economic sustenance from the center, whereas the center depends on the periphery for labor, product consumption, new ideas (Hall, Stevens, & Meleis) and, in the case of BC, natural resources.

Many of the barriers to political inclusion identified by the women in this study are reflected in the literature. Northern communities often have an education system that encourages women to stay at home, and many communities have limited day care programs which hinder upgrading for women with children (Wall, 1993). Northern single-industry towns often enforce male stereotypes, and undervalue women's work in the home and in the community (Luxton, 1980). Other barriers to participation in political life include lack of time due to work and family commitments, and the perception that women do not have the education and experience needed for community decision making (Wall). Northern women often do not have access to 'the old boys network' which would give them information and confidence and facilitate their political inclusion. Factors that decrease participation in community life may mean that northern women are less heard and seen and, accordingly, have less power to influence community decisions. As previously discussed in this chapter, many of the women in this study experienced these barriers to political inclusion. Consequently, northern women may lack role models and a history of being involved in decision-making bodies, which may result in women not valuing their own experiences, abilities, and perspectives (Wall, 1993). Thus, their political power is diminished.

Heald (1991) has stated that "identification with a geographic region can be a positive force, giving meaning, identity, community...However, region also determines difference, and difference is most often understood as disadvantage" (p.112). People who are seen to be different may be pushed to the periphery, excluded from mainstream society with its resources to the less acknowledged and supported margins and border areas (Hall, Stevens, & Meleis, 1994). This peripheralization puts at risk access to needed resources to sustain health and quality of life, as identified in the previous section. In order to change disadvantage, northern women require power. However, limited power is an element of the lives of many northern women.

In summary, the limited power that northern women experience can often be attributed to geographical and gender variables. The geographical location of the north contributes to the marginal status of the north as a whole. Within this context, the resource-based economies of the north further marginalize women because of gender segregation and undervaluing of women. This marginalization leads to women's decreased participation in the life of the community. As a consequence, northern women experience limited power and perpetuated marginalization.

Being Silenced

In this section, I describe the silencing of northern women as expressed by the women in this study, particularly through their perspectives about participation in research in general, and this research in particular.

The silencing that northern women experience was revealed in comments about the value of their participation in this research. The following quotes illustrate that women felt that the research finally gave them a voice:

> I'm so grateful that you're doing this study. I guess I haven't gone beyond thinking about how wonderful it is that someone's finally sitting down and reaching out to women and finding out what people are thinking. This is so needful. You know, I talked...last time about women not having a voice - well, this is giving women a voice. (Jocelyn)
>
> I admire you so much for having done this [research] - I know it was a major work...our little voices wouldn't be heard if it wasn't for you drawing them out and possibly putting them where they will be heard. (Amelia)
>
> I think what you're doing is really valuable. This [research] needs to be done...Because men have been in control for so long and women have just had to go along with it. They've had no say. They've had no say at all. (Signe)

Signe's comments indicate that having a voice gives women power and control.

This research was viewed as important in facilitating change partly because it seriously considers and includes women's perspectives. The need to be consulted and to be taken seriously is clearly evident in Eileen's comments:

> You're asking my opinions. You're giving me a chance to state them fully...You're making me feel heard. And then it's going to go somewhere and I hope be useful. And I feel - for that last part especially - you can hear my voice here [her voice was trembling with emotion] - I really feel honored that it's going to be useful in some small way - I do.

Some women who felt marginalized in health care situations believed that expressing their experiences through the research might help to improve health care and prevent similar negative interactions for other women. For example, Eileen suggested that research that is focused on women leads to visibility with each other and subsequent empowerment:

> It pleases me to have it focused on women because I think women up here feel disempowered and under and invisible and I think it will help women become more visible to themselves and that's part of becoming more empowered.

As well, for some women, voicing their experiences and frustrations was cathartic and therapeutic. Fred valued the opportunity to express her feelings:

> What prompted me to come forward is the lack of specialists around here and just generally it makes me mad. Well, I wasn't so angry after I'd vented it all over at you, I guess. After I talked to you, I guess I wore it off...you're a very good listener. Cause I guess that's what you're doing is listening and you did a good job of it.

Rhoda was attracted to the study because it provided an opportunity to give voice to her experiential knowledge:

> Being heard - being able to express what's going on in the medical field from my experience and having had major surgery and the experience I went through with that - I thought was really important for your research because, like, it's new to me, it's fresh to me and my anger was still prevalent.

Some women volunteered to be part of the study to represent a constituency or perspective that they felt had been particularly silent or under represented in research. Some of this silence can be attributed to the uniqueness and low prevalence of some situations. For example, Elizabeth volunteered for the research because "I don't think there's that many of us that have actually lived all our lives in the north. [We] probably have a slightly different viewpoint". Lillian, an 86 year old woman who has lived several decades in the north, participated in the study because "I'm pretty well acquainted with the place and the people...I just thought it might be helpful because I've lived here a long time". Amelia noted that, "It seems that we sometimes feel that our voices aren't heard in rural areas. Like if you live in the city, you'll get some attention, but if you live in the country, you probably won't". When Rosie first contacted me to participate, she stated, "You want remote - well, I'm remote". Mary, an Aboriginal woman, stated:

> A lot of times Aboriginal women's voices are not heard. And so I thought, 'Well, we do have a lot of health issues and our voice is never really considered'. And so I thought, 'Okay. If I can be part of this, maybe we can have a little bit more of a say'.

Ruhi, a South Asian woman, also wished to bring a cultural perspective to the research data, "I think mostly East Indian people don't [participate in research]...they think you know, this will be their name..on there...our family will get mad...and mostly people who are old - they don't know the language".

It is obvious from these comments that the women in the study highly valued the fact that northern women's health was finally being investigated, and that they had a voice in that research. However, the words alone do not always clearly convey the deep desire that women in the study had to be heard. The emotional tone and the nonverbal communication, such as a trembling voice, direct eye contact and leaning forward, indicated the women's strong desire to be heard. In addition, it sometimes seemed that the women felt that they needed to speak forcefully so that they would be heard and taken seriously, perhaps because of previous experiences when their perspectives were not sought or heard.

The silencing that northern women feel was also evident in other research-related incidents. As indicated in the Research Method chapter, there was an overwhelming response to my recruitment invitation for participants in this research. Some women pleaded to be part of the research. One woman, for example, inquired whether I had anyone in my study yet from her community. When I responded in the negative, this woman stated, "Well, then you've just *got* to take me". Another woman, who I had not included as a participant, telephoned me 16 months after recruitment to volunteer to assist me with the analysis of the data, and to offer further information about women's health. Still another woman who was not part of the study emailed information to me. Women continued to contact me to be part of the study six months after recruitment was completed. These extraordinary efforts and interest indicate northern women's desperate need to be heard and the depth and scope of the silencing that many northern women experience.

The women's preferred method of data collection further revealed women's need to have a voice in direct and meaningful ways. Most of the women preferred face-to-face interviews, rather than telephone interviews. Although women would be listened to in telephone interviews, it seemed that the women felt that they would not 'really be heard'. Face-to-face interviews in women's communities, homes, and across their kitchen tables were important in conveying respect, increasing understanding, and decreasing the silence that many northern women experience. Casey explained:

> ...a lot of times up here we get a lot of phone research...and the people at the end of the line don't care. It's all written out for them...It's just cold...Whereas a face- to-face encounter - there's a body there, there's warmth, there's humanity. The eyes are very important. There's a connection.

Fred valued face-to-face interviews because they permit observation of nonverbal behavior and a personal connection:

> Well, just seeing the person and seeing their face and you know, you say something and they aren't...laughing at you. I guess a lot of communication is body language, that they aren't a threatening person. Or just a voice on the phone - it's really impersonal.

By implication, it would seem that some northern women may fear ridicule and may feel threatened when they voice their perspectives in impersonal ways.

That marginalized persons are denied voice in research is well documented. In research, marginalized people are seldom directly asked about their opinions and experiences, the problems they face, obstacles that block access to health and other resources, and what they believe would remedy their situations (Hall, Stevens, & Meleis, 1994). As a result, marginalized people and their lives may be misunderstood and neglected, and the problems and remedies ascribed to them by the center may be inappropriate, inadequate, or just plain wrong. Collins (1989) has stated, "One cannot use the same techniques to study the knowledge of the dominated as one uses to study the knowledge of the powerful" (p. 751). Research with marginalized groups should follow a narrative style whereby those in marginalized settings can describe in their own language their contexts, needs, strengths, and strategies for survival (Hall, Stevens, & Meleis, 1994). Such research helps to recognize the uniqueness and differences, as well as the similarities, of the persons with whom the research is being done (Olesen, 2000). Marginalized people should be viewed in research as experts in their own lives. Comments by the women in this study and their nonverbal communications reveal just how important it was for them to feel respected, included, and encouraged to 'come to voice' in this research.

Other indicators of northern women being silenced include the limited number of women in public positions of authority and decision-making. For example, during the course of this study, the Prince George city council of 10 elected members included only two women. Prince George has only had one woman mayor in its almost century long existence. Northern women Members of Parliament and Members of the BC Legislative Assembly are also very much in the minority. These indicators illustrate some of the silencing that northern women experience in public venues. Indeed, social and political roles in resource-based communities often reflect the power structures inherent in employment in those communities (Delaney & Brownlee, 1996). Because women do not hold publicly visible or powerful positions within resource-based industries, their chances for attainment of civic and other political offices in northern communities are also compromised.

In summary, being silenced in the north is a common occurrence for northern women. Women's perspectives about the research process and the limited presence of women in elected public office illustrate the depth and scope of silencing that northern women experience. This lack of voice contributes to the exclusion of their perspectives, values, abilities, and desires from the life of northern communities, thereby contributing to further silencing and marginalization of northern women.

Summary

Being a woman and living in the north subjects women to marginalizing conditions and consequences. Northern women's marginalization results from the historical, physical, sociocultural, and political environments in northern BC. The degree of marginalization is further influenced by personal factors such as physical and mental health status, age, education, finances, cultural background, and past experiences in marginalized settings. Marginalization is experienced as isolation; limited options of goods, services, and education; limited power; and being silenced. Women are isolated from others by the physical and social environments. Attitudes and beliefs regarding women often create a social environment that serves to isolate women from others. Limited options of goods in terms of food and clothing also exist in northern communities. In addition, traditional and alternative health care services, health promotion and disease prevention services, education resources, and arts, recreation, and technology services and resources are limited in many northern communities. Limitations in terms of gendered economic environments and community attitudes towards women limit women's power. Northern women's silencing was revealed in participants' comments about their valuing of this research and their participation in it, and in the limited number of women in public positions of authority and decision-making in the north. These experiences of marginalization result in northern women being made vulnerable to risks to their health. Northern women's vulnerability to health risks is the focus of the next chapter.

CHAPTER VI

FINDINGS: VULNERABILITY

Within the northern context, women experience marginalization characterized by isolation, limited options, limited power, and being silenced. Marginalization leads to vulnerability to threats to women's health and women's quality of life. In this study, vulnerability emerged as the basic problem that northern women needed to address to maintain their health. This chapter discusses the vulnerability that women in this study perceived and experienced as a result of their marginalized status in the northern context.

Vulnerability in this study refers to being exposed to health risks and the consequences of those risks. Northern women in this study experienced vulnerability to physical health and safety risks, psychosocial health risks, and risks of inadequate health care. Several factors affect the nature and degree of these risks. The northern context, with its physical, sociocultural, and political environments affected women's vulnerability directly and through its effect on marginalization. The degree to which women experienced marginalization, that is, isolation, limited options, limited power, and being silenced, influenced the degree to which they were vulnerable to health threats. In addition, personal factors such as health status, age, and financial status influenced the effects of marginalization on women's health. Vulnerabilities to health risks and factors that influence these vulnerabilities are addressed together in this chapter.

Physical Health and Safety Risks

Northern women experience vulnerability because their physical health and safety are often put at risk. Women in this study perceived that the northern physical environment contributes in large measure to this risk by isolating women, putting great demands on them, and limiting their access to resources. *Climate, geography, wildlife, employment in the physical environment,* and *pollution* were noted by the women in this study as particularly problematic. Although these factors are listed separately, they are discussed together as they often interact to compound health and safety risks.

Climate and geography present major risks to women as they make travel hazardous. In northern BC, people must travel several hundred kilometers from one community to another community. Weather and road conditions can vary markedly in and between communities and over the time it takes to travel between communities. The geography of northern BC includes open areas as well as mountain ranges, all of which pose challenges to driving, especially in winter. In addition, the decreased number of daylight hours in winter increase the challenges of driving long distances. As a result, in winter especially, northerners who travel are at risk for road accidents and exposure to extreme cold and inclement weather.

Several women noted that they are unable to travel or will postpone travel in winter. Lilac stated that she "will go to my doctor again when the weather looks a bit better, [when it] stops snowing so much". Christine noted that, in the north, "You learn to cope. If you can't go for your physical or your surgery, if you don't have to do it right away, you can put it off until spring when traveling's easier". Rosie, a woman who lives in a remote area and who depends on travel on a road as well as a river, explained:

> Up until 10 days ago, you couldn't cross the river, not even walking. It was full of ice but there was still open holes [of water] and it wasn't safe. Right now, you can walk on it, and half of us [in the community] have our vehicles on this side [of the river] and half on the other side. So, at least if we had to get out now, we could walk across and use somebody's vehicle. So there is access that way.

As a result of such weather conditions, women need to postpone access to physicians and other health care providers unless care is absolutely necessary. Therefore, women's ability to access care not only for acute health problems but also for diagnostic, screening, and health promotion and illness prevention services is compromised by the northern environment. This means that northern women may live with morbidity longer than other women, thus compromising their quality of life and making treatment more difficult when care is finally sought. For life-threatening conditions such as cancer, the postponement of diagnosis and treatment could result in the spread of the disease with serious consequences, including death.

For certain groups of northern women, climate and geography are particularly problematic. For the elderly, physically challenged, and others with mobility issues, getting around in winter can be particularly risky and difficult, especially in small communities where no public transportation exists. Fred, a woman with multiple sclerosis, drives in summer but rarely in winter because "you are putting other people at risk. It's not just yourself...it's everybody else". The combination of winter weather and the lack of a public transportation system means that Fred must rely on friends and family or pay for taxi services. Thus, the northern climate and the limited transportation options can compromise women's independence and their ability to interact with others.

Wildlife can also pose risks to safety. Grizzly and black bears, moose, wolves and cougars are prevalent in the north and may come close to human habitations. Rosie noted that wild animals frequently stroll through their farm yard, "We see grizzlies, black bear, moose. Moose with young ones, they are probably the ones you need to worry about the most". Robin described some safety issues regarding wild life near her farm,

> ...we've had bears up by our spring...We've had deer and moose walk through our front yard here...I was out in the garden there and I had that feeling [that] somebody's looking at you, watching you. But I knew I was silly because I was home alone. And then a dog that we had came up by the garden in a pointer position...so I did turn around and looked up the hill and yes, sure enough, I was being watched by a bobcat...

Another source of physical health and safety risks is the nature of women's work in northern environments. Northern women's work can expose them to occupational hazards that may not be as prevalent in warmer, southern, urban environments. Christine, for example, described some of the injuries she sustained when she worked as a farmhand on a ranch, "I've been stepped on...bit...squashed... thrown off horses into fences, over fences, under horses, into cars, off of tractors (laughter), off the hay wagon...I've broken my baby fingers three times". Lilac, Signe, and Robin suffer from arthritis. Robin believed that arthritis may result from occupational injuries due to northern types of work:

> [Arthritis may be common in the north] because of the type of work - we've made so many injuries to ourselves...we'd run out to the chicken house in gumboots in the winter - not good for your feet. The hard work that we do [on farms]...it takes a toll on the body.

Air pollution that results from resource-based industries was noted by several women as another environmental threat to their physical health. Christine and Mary remarked that asthma and other respiratory symptoms have increased for them since they moved to northern communities. The Provincial Health Officer (1996) has noted that all of the northern health regions have measures of inhalable particulate levels that are above the level at which there may be health effects; Quesnel, a small city included in this study, has the highest levels in the province. Quesnel, like many northern communities, is located geographically in a river valley; these valleys often create pockets of slow moving and captured air. In addition, many northern communities were established and grew to their present size because of air-polluting industries such as pulp, paper, and lumber mills. Although initiatives to reduce pollution from wood burning in northern forestry industries have been effective to some degree (Provincial Health Officer, 1996), obviously contamination of the air remains a threat to physical health in many northern communities.

In summary, the physical health and safety risks that northern women are exposed to are diverse and formidable. The nature of the northern physical environment - its climate, geography, wildlife, employment, and pollution - can severely affect the health and safety of northern women.

Psychosocial Health Risks

Isolation coupled with northern attitudes that limit women's options, power, and voice result in psychosocial health risks for northern women. These risks include *threats to well-being, abuse*, and *social and mental health issues*.

Threats to Well-Being

Attitudes about women coupled with physically isolated settings can result in and accentuate feelings of being personally threatened. Casey described a threatening incident that occurred when she and a girlfriend were out fencing on her ranch:

> ...I had an incident with some BC Rail fellows that drove by and made a really rude, lewd kind of remark and facial...body language that was really inappropriate...it was the most threatened I'd ever felt on the place...

As a human services worker in a small community, Jocelyn has a high profile. This, coupled with her private life in an isolated rural area, has created feelings of insecurity:

> ...clients one particular weekend...tracked me down and I thought, "If they can track me down, so can the drug dealers who are threatening my life"...I'm not paranoid by any means, you know. I live on my own out in the country...but I do have to address safety issues in my life so, yeah, I'm always thinking about that.

Elizabeth experienced a threatening incident when she lived in a very small, isolated, and sparsely populated community:

> I've had a stalker for a couple of years and his wife thought I was having an affair with him and tried to run me over...To me, that's [being stalked] not necessarily a problem with the north, [but in the north] how do you get away from these people cause where are you going to go?

Comments by Casey and Elizabeth point out that threats can result from two very different, opposing characteristics of isolated settings - being isolated or having excessive privacy, and lack of privacy and anonymity. In Casey's situation, the isolated environment exposed her to the risk of assault because of a lack of help that is close by. In Elizabeth's situation, the familiarity inherent in her small environment exposed her to a continuous threatening situation because there was no place to escape to that would provide her with anonymity. Thus, the social environment - whether it be isolation or familiarity - can be a significant factor in the type of psychosocial issues that can arise, and the ways in which women can address these situations.

Some women experienced personal threats to their well-being because of limited financial resources and limited options in their communities. Signe, an older woman with health and mobility problems and a family of cats, required affordable and accessible accommodation that would accept pets. She did find such accommodation; however, it threatened her safety, as it is located in "the needle exchange area...we're having all the hooker problems...I've had my car vandalized a number of times in the underground [parking lot]". Nevertheless, Signe philosophically stated, "Sometimes you have to live where you wouldn't choose to live - it's the only place you can find where you can [afford to] live". For some women, then, living in an unsafe place and enduring threats to one's well-being is a "choice" fostered by lifestyle values and limited personal and community resources.

Abuse

The women in this study had various understandings and perspectives about the incidence and nature of violence in northern communities. Most women stated that they had no experience with abuse, or that they did not know of someone who had been abused. Two women in the study did admit to abusive experiences from previous spouses and a parent.

Many women suspected that there could be a high incidence of violence against women because of the physical and social isolation inherent in northern rural living. Alice stated, "I always figured that isolation brings more abuse - a woman is kind of trapped". Christine explained, "Abusive men isolate their women and [in] the north, you're already isolated to some degree". Isolated individuals can become marginalized with fewer social connections and supports; these women are more susceptible to abuse and violence when they are cut off from the support of family, friends, and community resources (Flaskerud & Winslow, 1998).

Attitudes in the north towards women may create social conditions in which women are made more vulnerable to abuse. Jocelyn, a human services worker in a small community, spoke about some of these attitudes and the resultant risks for women:

> The vast majority...almost half [of my clients] at any one time are women who have been victimized...threatened...physically beaten...sexually assaulted...The emotional control I believe is there...forbid your wife to listen to the radio station that she wants to listen to - that's certainly a form of control...women do suffer because of these attitudes.

Other northern attitudes towards women limit their potential and increase their vulnerability. Expectations that women will marry at a young age may contribute to social situations where women and their children become dependent on husbands for economic and social support. Christine explained, "Women [are expected] to get married very young up here, generally in high school or just out of high school." People with little education and few economic resources have fewer choices and are vulnerable to control and victimization (Sebastian, 2000). Thus, with limited expectations and options for education and employment, women in the north may have a difficult time leaving abusive situations.

In addition to the contributing factors of geographical isolation and gender attitudes, abuse of women in northern BC may also have historical origins. The frontier attitude needed to survive and settle in the harsh environment of the north may have continuing effects on the roles and expectations for women, as Christine explained:

> A lot of people up here were settlers and come from the very old school of a woman is for birthing children, for working on the farm, and she's yours. You own her. And I think a lot of that is still very, very much alive.

The above factors that contribute to violence and its resolution in isolated settings have been identified in research by others (Fishwick, 1993; Goeckermann, Hamberger, and Barber, 1994; White, Katz, & Scarborough, 1992). Southcott (1993) has suggested that the isolation and rugged conditions that characterize many northern resource-based communities highlight the alienation, brought on by gender inequalities, faced by women in society as a whole. Resource-based economies with their emphasis on male employments and male priorities contribute to women feeling isolated, powerless, and depressed (Nadeau, 1982). Nadeau suggested that the loneliness, insecurity, and alienation of daily life to which northern women are exposed is reflected in the high incidences of wife assault, child battering, and alcoholism and other substance dependency in northern communities.

It is estimated that, in Canada, one-quarter of all Canadian women have experienced violence at the hands of a current or past marital partner, and one-half of all women have experienced at least one incident of violence since the age of 16 (Canadian Panel on Violence Against Women, 1993). The Provincial Health Officer for British Columbia noted in 1996 that abuse is still a major health issue in that province (Provincial Health Officer, 1996). Therefore, it is very probable that, in northern BC, with its greater isolation, fewer resources, and attitudes and expectations about gender roles, the incidence of women abuse is at least equivalent to, if not more prevalent than, the national situation.

Social and Mental Health Issues

The northern context significantly affects women's social and mental health. A woman in a National Film Board of Canada (NFB) production entitled *No Life for a Woman* (1979) recalled the first letter she wrote home to her mother after arriving in McKenzie, a small town in the Northern Interior health region of northern BC. She wrote, "Remember when I married Bob and said I'd follow him to the ends of the earth? Well, finally Mom, I'm here" (NFB, 1979). Although northern BC is not the "end of the earth", the northern BC environment does pose challenges on various fronts to women's social and mental health. The women in this study noted that feelings of isolation, boredom, loneliness, and depression are social and mental health issues for women in northern communities. These issues are affected by distance, limited amenities, social attitudes, and the physical climate of the north.

The northern location with its distances from large cities and from family and friends affects women's social and mental health by contributing to feelings of isolation. Women's lives are diminished and circumscribed because of the limited options available for social and cultural pursuits in small northern communities. For example, Linda noted that she and her family often visit a larger center to obtain these amenities:

> Shopping is much more inviting there [in Prince George].There's other stuff, in a bigger center you have more options. They have the wave pool and water slide now, and the activity place for the kids. Most small communities don't offer a lot of those things. I feel that [my community] is definitely lacking in entertainment things.

Only three urban centers in the two health regions in this study exceed 15,000 people (McCann & Gunn, 1998). Prince George, the largest of these three centers, is populated by approximately 85,000 people and, thus, contains some shopping, recreational and cultural resources and amenities. Access to these resources is much more limited in most other northern areas because of smaller populations.

Women also experienced more limited opportunities to share similar interests with others. Leah stated, "I don't see a lot of choices for women here. Like, in Victoria, there's all these feminist groups. Anything you want to join, you can join. Here it's like an old boys club". Eileen noted, "I don't have a group of writers to meet with here...If you're any kind of artist, life here feels very constrained in terms of not having like minds". Marie found it "difficult to find people here that are interested in more than the day-to-day cooking and scrubbing and going to work and coming home". Thus, women's social health can be compromised by the limited options for socialization and cultural enrichment that exist in northern communities.

Social isolation is also the result of values and attitudes that exist in many northern communities. Women whose lives do not fit the mainstream role expectations of wife and mother are often exposed to social isolation. Women who do not or cannot subscribe to one or both of these roles expose themselves to invisibility and an undervaluing of their desires, perspectives, and strengths. For example, Casey, Elizabeth, Leah, and Marie noted the "couples-oriented" nature of their communities and how this affected their mental health. Elizabeth stated, "As a single person, you never quite fit in". Elizabeth, Leah, and Marie, all single women, also noted the lack of recreational opportunities for single women due to the couples orientation of their community. Casey, whose husband is away from home for long periods, felt that socialization is limited during the times when he is absent:

> It's difficult...it's sort of the worst of both worlds cause you're not really single but you're a third wheel when you go out with couples because people tend to socialize as couples, so part of that [socialization] gets put on hold...

Casey also noted that since she and her husband now have their niece living with them and so now 'have a child', she feels more included in community events than when she did not have a child.

Being socially connected was seen as important for women's mental health. Eileen noted, "Being emotionally healthy means keeping up connections with people, going to visit and having people over or little gatherings". Rhoda stated, "I think that's [establishing connections and friends] something women [just] do, no matter where they are". However, as new residents in a northern community, women may be viewed as 'outsiders' and may consequently find it difficult to make friends or participate in the life of the community (Gill, 1994; Lee, 1998b). Elizabeth noted that she had been in her community for ten years and "I'm just now feeling like maybe I belong here".

Social and mental health issues such as boredom, loneliness, and depression may also arise because of the northern climate. The long cold winters hinder women's ability to get out of the house, especially if there are small children or if women have mobility problems due to age or disability. Several women in this study noted that the long, cold, dark winter season contributes to the depressive condition termed seasonal affective disorder. For example, Leah stated, " Winter is so damn depressing here. Seasonal affective disorder syndrome - half the town has it". Gill (1984) noted that it is during February in particular that the incidence of mental disorders among northern women known as ‘cabin fever’ or ‘housewife psychosis’ reach their peak. However, it isn’t only the long winters that contribute to boredom, loneliness, and depression. Carmen explained the importance of expectations as they relate to environmental satisfaction:

> It’s not just the winters being long...But this [is] spring...We had a nice mild winter, but it’s dragging on now. Like it’s supposed to be nice and warm [and it’s not]...this is the time when I get what they call cabin fever. Because you’re sick of this.

Therefore, long and never ending winters that confound expectations for a warm, sunny spring and summer contribute to women’s vulnerability to mental health issues. As the cold weather and grey skies of winter drag on into the spring and summer months, feelings of depression can result.

Although information about the extent of mental health issues for northern BC women is not available, depression and anxiety are diagnosed more frequently in women than in men in BC (British Columbia Provincial Health Officer, 1996). Findings from this study suggest that physical and social factors in the north may contribute to women’s vulnerability to mental health problems. Factors such as remote settings and extreme climates which inhibit socialization, and values in small communities that discriminate against people with alternative lifestyles contribute to women feeling and being excluded and undervalued. As a result, women are vulnerable to disruptions in their mental and social health.

In summary, northern women experience psychosocial health risks that include threats to their well-being, abuse, and social and mental health issues. These risks were perceived by the women to be due to physical isolation and limited options, and to social isolation that is influenced by attitudes towards women. Risks to women’s psychosocial and physical health are compounded by women’s lack of ability to access health care and other resources, as discussed in the following section.

Risks of Inadequate Health Care

Women in this study perceived that limited options in the north and the physical and sociocultural environments result in limited or complete lack of access to health care for northern women. As a result, northern women are placed at risk in their ability to obtain treatment and health promotion and illness prevention services, to make informed decisions about their health and health care, and to be empowered and responsible for their health. These risks to health are further accentuated when women do not have adequate finances, time, and the physical ability to access resources at a distance. As a result, northern women have increased risks of developing illness, of postponing care so that illness becomes more severe and less treatable, and of being less able to care for themselves in well and ill states. These risks will be discussed in this section in terms of the *difficulty getting to resources* and *inadequate and inappropriate resources.*

Difficulty Getting To Resources

Northern women have difficulty getting to resources due to the *physical environment, limited personal resources,* and *northern attitudes about illness* and, thus, they experience vulnerability and risks to their health.

The harsh and isolated northern physical environment decreases women's ability to access health care resources. Cold stormy weather makes accessing resources in winter problematic particularly for elderly and physically challenged women. Fred, a young woman with multiple sclerosis, does not drive in the winter due to the weather and her weakened physical strength to endure vehicle breakdowns, should these occur. Rather, she depends on friends and family, or takes the bus. To maintain her self-esteem and independence, Fred prefers to rely on herself as much as possible; she will sometimes forego health care and stay home rather than inconvenience others. Lilac, an older woman who drives to Prince George for physician services, also deferred travel in inclement winter weather, "I will go to my doctor again when the weather looks a bit better, stops snowing so much". Thus, women may choose to forego accessing health care in winter, even if these services exist at an accessible distance in summer. As a result, in winter, women's physical and mental health are especially compromised.

Women who live in particularly isolated or remote settings are especially vulnerable to the effects of distance and weather. Gert, a human services worker, noted that, "if you're trying to reach Aboriginal women in some of the villages, not everybody has a phone". These women are, therefore, more vulnerable because they cannot telephone out nor can others telephone these women. Mary described how limited personal resources create other challenges when accessing care from a distance:

> if [First Nations] women do live in their community, they have to travel so far to come and see to something...For them, it's, "Oh, I've got to plan because it's going to be a whole day trip. I've got to save this much money to go up and arrange for people to drive me. When I'm there...I'm going to have different meals and how much that's going to cost. I've got to look for babysitting for the rest of my family". So, it's more of a hardship for them to try to get medical needs.

Rosie, who lives in a very remote area, described some of the isolation that's characteristic of her community:

> Ok, right now I can give you a prime example. It's been really cold and windy...until a week ago, you couldn't cross the river and there was about a week where the back road was snowed right in...And the train isn't even running on time so you can't rely on it either so we are really isolated, you know...There was a whole week there where there was no way you could get out and there was no way a chopper could've got in...We've had four and a half feet [of snow] within a seven day period.

Thus, northern women who are isolated by distance, weather, or limited personal resources are often unable to access care and information. This situation compromises their ability to make health care decisions and engage in self-care and treatment practices. As a result, women may live with illness, pain, and undiagnosed and untreated conditions for long periods of time, thus compromising their health. Signe, a woman with a low income who cannot access surgery outside the north until she can save sufficient funds for air fare, commented on how her condition is deteriorating over time:

> I used to go to the symphony, but I can't sit any longer. I'm stuck at home now. I've been in so much pain for so long, I think I just can't handle it. I'm on morphine, one a day...but there's many restless nights or nights I don't go to bed at all [because of the pain].

In addition to distance, weather, and limited personal resources, northern attitudes about illness can compromise women's ability to access health care. Northern attitudes and expectations of ruggedness and self-reliance may cause northern women to ignore symptoms or postpone visiting a health care provider, as Rosie noted, " Most people here will not go near a doctor unless they're seriously ill. In most rural communities, that's true. [The attitude here is that a] doctor is someone to go to when [you're so ill that] you can't get off the floor". Rosie felt that the northern attitude of self-reliance "carried to extremes does more damage than good". Discriminatory attitudes towards mental illness may compromise access to mental health services, as Marie, a teacher who suffers from a mental illness, noted:

> You can't go to a local support group...It's [mental illness] just not accepted yet. People are still afraid of it like they were of epilepsy years ago. You have no idea the damage and harm that parents can cause when they decide to attack a teacher, spread rumors or gossip. I'd have to go out of town to keep my anonymity.

Because of these northern attitudes, women may be reluctant to seek care, they may live with physical and psychological health issues for longer periods of time, or they may not seek care at all. Travel outside a community for care is only a possibility for those women who have the time, finances, and energy to do this.

Inadequate and Inappropriate Resources

This section addresses northern women's specific health risks and lack of access issues as they relate to *limited diagnostic and treatment resources, inadequate menopause and mental health resources, limited alternative therapies,* and *inappropriate provider attitudes.*

Limited Diagnostic and Treatment Resources

Women in this study experienced several health conditions including multiple sclerosis (Fred), fibromyalgia (Linda, Rosie), cancer (Vicki), infertility (Casey), allergies (Marie), megaloblastic anemia (Vicki), diabetes (Mary), recovery from a heart attack (Gert), recovery from a stroke (Margaret), an undiagnosed auto-immune type of disorder (Barbara), and osteoarthritis (Signe).

Although these conditions are not always directly attributable to the northern environment, women in the north who experience these conditions are made vulnerable because of the lack of accessible and suitable diagnostic, treatment, and recovery resources in small northern communities. For example, Elizabeth and Vicki commented on the political decision not to build a cancer diagnostic and treatment center in Prince George, the main health care referral center in the north, but rather in a southern community which is within driving distance of the main cancer clinic in Vancouver. Elizabeth stated with much irony:

> They put the cancer clinic in Kelowna...Well HELLO! Who is that good for? Prince George would have made a whole lot more sense...But we go with this political attitude - everything's down there [in the southern part of the province].

Signe, an older woman with decreased income who required specialist services in Vancouver - a plane trip away - needed to compromise her health and quality of life so that she could access care in Vancouver:

> I cut back on groceries. I mean...I'm not starving, but I cut back on my groceries...because I have to go down [to Vancouver]...you always manage, but it's tight...And I didn't have the money in time to get my ticket.

Thus northern women must sometimes compromise their health in the short term, such as by buying food of lesser quality and quantity, in order to access funds for care at a distance. For women who have fewer resources and thus less margin for compromise, accessing care outside their communities may only be possible after an extended period of time during which money can be saved or obtained from family and friends.

For those women who do not have the funds, time, or other requisite resources to obtain care outside the north, care is limited to what is available in the north. In many northern communities, hospitals are closing, and physicians are moving away or, if they stay, they are becoming overworked. There is also a shortage of nurses to staff health care institutions and to act as health consultants to women. Thus, women may have difficulty accessing quality care in hospitals, as Signe experienced:

> [Recently, when I was ill] Dr. C. said, "You should be in the hospital, [but] there's no beds". [Another time] when I broke my pelvis, I was in the waiting room off the emergency room on a stretcher for 10 days before they got a bed for me. And I got pneumonia from lying there. Our health care system is really in bad shape.

Some women noted that they had difficulty obtaining a second opinion because there either was no second physician in their community, or other physicians refused to see them because they were already a patient of a colleague. Ruhi stated that "If I have a doctor, then other doctors don't want to take you". Some women preferred to see a female care provider, especially a female physician. However, female physicians are a rarity in northern BC. As a consequence, northern women are exposed to care that is often inadequate and inappropriate and which increases their vulnerability and risk. Women who cannot obtain care elsewhere may receive no care at all.

Although people in small northern communities have always been at risk for decreased access to diagnostic and treatment resources, women noted that this situation is deepening and spreading throughout all northern communities as a result of political cost saving decisions to close hospitals in larger as well as smaller communities. Mary commented:

> If doctors could be...persuaded to stay in smaller communities...where all these little hospitals are closing [then]...medical attention to more isolated communities [further] north would also be improved. But if it's deteriorating where we think it's not isolated, it's going to deteriorate even further in the

> more isolated communities.

Women in larger centers who might expect to be at less risk for inadequate treatment are experiencing increased risk, and women who are already vulnerable because of their isolated situations are experiencing even greater vulnerability. For example, women are having to travel further for care, as larger communities close hospitals and lose physicians and nurses. In such a situation, women, as an already marginalized group with little power, are particularly vulnerable.

Inadequate Menopause and Mental Health Resources

Although there is a need to enrich all types of health care in the north, two health areas were identified by the women as particularly important: menopause and mental health. Menopause may have been identified as an important area because of the large numbers of women in the study who are about to experience or who are presently experiencing menopause; 13 of the 25 women are in their 40s or 50s, and 8 women identified menopause as a major health issue.

Lack of available and appropriate health care for menopausal women in northern communities was viewed as particularly problematic, as Rhoda explained:

> I think it would be wonderful to set up some kind of a process for women going through menopause...we're struggling. So, what can we do and how can we feel better?...if you've got a physician like I had who says, "Frankly, I don't care about your sweats" - then what?...We're not kept informed...I want to know what the possibilities are - *I want to know. And we all want to know* [Rhoda's emphasis].

As indicated by several women, the attitudes of some physicians about menopause and menopause education can be less than helpful. Vicki explained that a female physician from the lower mainland who gave a workshop on menopause in Vicki's community had experienced the negative attitudes of local physicians:

> [The female physician] told us without identifying the doctor at that meeting, [that he] had said to her, 'The only reason that I'm here is to find out what to do with my wife since she's menopausal'. And I think that sort of typifies the

> attitudes of the male doctors that we have here...

As a consequence of northern women's inability to access health education and supportive health care providers, they may experience unnecessary or prolonged menopausal symptoms, and they may be less empowered to prevent and address symptoms. For example, Jocelyn learned important self-care strategies at a menopause seminar; these strategies would have been denied her if this seminar had not been offered:

> We had a wonderful seminar through the women's resource center on menopause...and I took away from that the fact that I should be taking vitamin E. Then I started reading more about vitamin supplements so I take a few vitamin supplements [now].

Inadequate resources for mental health issues also threaten northern women's health. Mental health conditions experienced by northern women in this study included seasonal affective disorder, obsessive compulsive disorder, bipolar disorder, and the effects of substance abuse and woman abuse, as previously mentioned. All of the women who experienced and noted these conditions and effects felt that there were inadequate resources in the north to help them. For example, Leah, a woman with obsessive compulsive disorder, explained, "The support mechanisms are not in place [here] for mental health. There is one psychiatrist and nobody has good things to say about her, and I just won't go to her". Park and Rhoda, both of whom are involved in women's shelters and women's centers, felt that there were inadequate resources to cope with violence and substance abuse issues. Rhoda commented:

> And the other thing is the alcohol and drug addictions of women in this community - there is absolutely no place for a young [woman to go]...the street girls are the ones...we need something for them...they have no counseling - no follow up...We have a big problem of heroin in this community with young women and young boys.

Although Park noted that both women and men "are just starting to talk about [abuse] issues now", lack of services to assist women and men who have experienced abuse contributes to further abuse of women. Eileen also noted the lack of resources for children who witness violence:

> I tried to get my daughter into something for children who witness violence. It was very frustrating...there were no services that were oriented towards the whole family...because of the legal involvement and because of the mental health system...everybody's got to be divided up...Pitting us against each other...There's nothing else here.

More preventive programs were also recommended, as Park explained, "...in terms of violence prevention, we could do more workshops in the schools and include diversity like the issues such as homosexuality, class issues, oppression, and so on in the schools, if we had the money".

In summary, women in this study perceived that inadequate resources for menopause and mental health issues threaten women's health. As a result of inadequate resources, women may receive inappropriate health care, or they may choose to avoid seeking health care altogether.

Limited Alternative Therapies

As indicated previously, women in the study highly valued care provided by alternative health care providers such as massage therapists, naturopaths, herbologists, and others. However, particularly in small communities, alternative care providers either did not exist, or they provided only periodic services. Moreover, women were unsure about the quality of care provided by itinerant practitioners. Women who did not have the time and money to access these practitioners were more limited in their ability for self-care and decision making about their health. Consequently, northern women were more vulnerable to conditions that may have been alleviated or prevented by alternative health care practices.

Women expressed the need for assistance in evaluating alternative therapies. For women who did have the finances to access resources, such as computers or personnel in distant locations, the need still existed for someone to help them understand and evaluate the people and information they were able to access. Jocelyn noted that, because there were few people in her community to consult about alternative health care, "I feel that I'm striking out in a whole new field and people who are leading me by the hand are the books I'm reading." Evaluation of health care personnel was also valued, as Rosie explained, "...women need to know how to judge the person they're going to. To see if what they offer me is up to the standard to meet their needs". Because of limited health care resources, northern women are limited in their ability to access and evaluate information about and care from alternative health care providers. Thus, northern women are vulnerable to alternative health care that is inappropriate, irrelevant, or even harmful (Tesch, 2001).

Inappropriate Provider Attitudes

Women in this study perceived that northern women's physical and mental health are affected by the attitudes of health care and other providers. Attitudes of physicians have been previously described in The Northern Context chapter. Essentially, these attitudes reveal an undervaluing and dismissal of women's experiences, concerns, and desires to participate in their care. These inappropriate physician attitudes contribute to women's vulnerability to health risks partly because of the limited choice of physicians in the north. Northern women have a restricted ability to change physicians or to access a second opinion from another physician. Therefore, women are often "stuck" with care from a physician, however inappropriate the physician's attitude may be. Christine elaborated on this issue:

> I've had doctors tell me that my problems are all in my head, when they've only met me just once or twice and they know nothing about me. That's probably true in southern latitudes, as well, but you have more choices. You don't like your doctor, you can find somebody else. Up here, there's not that much choice.

Marie spoke about the difficulty in finding a physician in a small town where there are few physicians and where physician attitudes towards empowerment for women may be problematic:

> Just recently I learned that my doctor is leaving...How to find another doctor in this small town who is going to help me help myself health wise and be as open

> and - how can I say it - not fearful for his own self-esteem as a medical professional.

If women are unable to access a physician who will provide appropriate and respectful care, they may choose a number of options. Some women may postpone or forego consultations with physicians to avoid unpleasant or inappropriate interactions. However, women may then be exposed to situations of prolonged pain, increased debilitation, and extended time until diagnosis and treatment. Women may choose to stay silent in interactions with physicians to prevent conflict. However, physicians may then not receive important information, and may thus provide inappropriate care. If women cannot find a suitable physician locally, they may travel outside the north for physician services. However, this is not a viable option for all women, as Jocelyn noted, "I'm fortunate in that I belong to that socioeconomic class that permits me to go [travel for health care], but so many women don't". As a consequence of inappropriate physician attitudes, then, northern women are at risk of not receiving timely, appropriate, or adequate health care.

Women also spoke about inappropriate attitudes revealed by priests, psychologists, and social workers. Rhoda described her experience of seeking counseling for sexual abuse she endured in a previous marital relationship. The priest she confided in "tried to hit on me" and the psychologist she next turned to for help also "tried to hit on me". As a result, Rhoda "stopped trying to get help and I was very angry at men and I think that I spent ten years of payback on men who didn't deserve it and I started drinking...I was really confused and mixed up". Christine noted negative attitudes when she saw a social worker for counseling:

> She was very angry, it seemed to me, about having to live up here. The questions she asked were almost irrelevant to what I was experiencing...I know the Ministry [of Social Services] up here has enormous case loads and it can be very difficult and depressing for them. [But] if you're not happy with your life, you're not going to help other people.

As a consequence, women may forego further contact with human service providers. Foregoing contact with providers who can help may result in women having to endure prolonged stress, and problematic and deteriorating personal and social situations.

In summary, northern women experience risks of inadequate health care. Women have difficulty getting to resources due to the physical environment, limited personal resources, and northern attitudes about illness. Northern women also have access to inadequate and inappropriate resources, including limited diagnostic and treatment resources, inadequate menopause and mental health resources, limited alternative therapies, and inappropriate provider attitudes. As a result, northern women are at risk of not receiving timely, appropriate, or adequate health care. Women may thus endure illness and other debilitating conditions and situations for prolonged periods of time, and their ability to promote their health and prevent illness and other unhealthy situations is also compromised.

Summary

Women in the north want the ability to live up to their potential, to have opportunities, and to live lives that are healthy. However, as this and previous chapters have articulated, women's health and their quality of life are often compromised in northern physical and social environments. This chapter has examined some of the vulnerabilities northern women experience, such as physical health and safety risks, psychosocial health risks, and risks of inadequate health care.

Northern women vary in their experience of these health risks and vulnerabilities. Northern context factors such as climate, distance, wildlife, and terrain affect women's experience of vulnerability and risk. For example, winter climate and the presence of dangerous wildlife increase women's physical safety risks. Variations in the experience of vulnerability are also due to the degree of marginalization women experience. Women who are more isolated and who have more limited options and power tend to have greater health risks. In addition, personal factors such as age and health and financial status affect women's experience of health risks. Certain individuals, such as older women, women with health problems, and women who have few financial resources have greater needs but fewer resources to address needs, which increases their vulnerability.

As a result of the various northern context, marginalization, and personal factors, northern women are often faced with adversities and hardships with consequent risks and vulnerability. The following chapter presents ways that northern women attempt to address the problem of vulnerability in order to stay healthy.

CHAPTER VII

FINDINGS: DEVELOPING RESILIENCE

This chapter presents the process, developing resilience, that women in this study used to address vulnerabilities to their health.

Developing resilience, as articulated by the women in this study, includes devising new and enhancing existing strategies that maintain and advance health in the face of health threats. As described in previous chapters, the historical, physical, sociocultural, and political environments of the north result in the marginalization of northern women. Marginalized northern women experience isolation, limited options, limited power, and being silenced. As a result of this marginalization, northern women are vulnerable to physical health and safety risks, psychosocial health risks, and risks of inadequate health care. Women address these vulnerabilities by developing psychological and behavioral strategies that foster resilience. More specifically, northern women develop resilience by becoming hardy, making the best of the north, and by supplementing the north. Although not every woman in the study used all of the strategies of developing resilience articulated in this chapter, all of the women, taken collectively, used all of these strategies at some point in their lives.

The physical, sociocultural, and political environments of the north affect the nature and types of resilience that women are required and able to develop. For example, women who live in very remote locations must develop physical and psychological types of resilient strategies that women who live in urban locations do not require. Thus, the degree of marginalization northern women experience influences the types of resilient strategies that women need and are able to develop. Various personal factors also influence how northern women are able to develop resilience. Factors such as age and health and financial status may increase or decrease women's abilities to develop resilient strategies to address vulnerabilities. Thus, it will be seen from the discussion in this chapter that northern women determine and develop strategies of resilience to address vulnerability to health risks, and these strategies are influenced by women's marginalization, personal factors, and their location within the northern context.

Strategies of Resilience

Hall, Stevens, and Meleis (1994) have noted that marginalized people comprise a community's most at risk, but perhaps most resilient, members. The northern women in this study, a marginalized and at risk group, develop and enact resilience by *becoming hardy, making the best of the north,* and by *supplementing the north.*

Becoming Hardy

Several women in the study believed that, to live in the north for any length of time, women need to be hardy. Rhoda stated, "In the north, we consider ourselves to be rugged and hardy". That women develop hardiness in response to the demands of the north is reflected in Elizabeth's statement, "[a woman] wouldn't last very long [in the north if she wasn't hardy] or she would become a hardy breed of person. It [the north] makes or breaks you".

Hardiness was described variously by the women as an increased feeling of confidence and the ability to carry on in spite of adversity. Elizabeth believed that a hardy person was "someone who's just sure of themselves and knows they can deal with things. They don't need someone else to do things for them. Self-assured...confident". Rosie felt that being hardy in the north meant that you were "tough as nails and have a really thick skin"; this helps women deal with hard physical work and challenging social situations. Signe felt that "because living is a lot tougher up here [in the north]", women need to develop "a certain sort of steel. No matter what happens, you just...carry on. You learn to accept...life". Lilac, too, felt that:

> it [the north] is not place for a little garden rose. You have to be hardy to accept the fact that it's cold outside and that you are living with people who have a rough exterior...they may lack education and social skills.

Becoming hardy helps women develop psychological and emotional resources that form the basis for their mental and physical health, as Robin explained:

> Hardiness is personality. It's got to be what you are that makes you connect with what is here in the north - what makes you feel good...healthy... fulfilled - all those things that make you feel emotionally healthy. Emotional health makes you become more physically healthy.

Thus, as described by the women in this study, becoming hardy is an essential personality characteristic that helps northern women develop and maintain physical and mental health. Becoming hardy for the women in this study included the strategies of *taking a positive attitude, following spiritual beliefs, developing fortitude,* and *establishing self-reliance.*

Taking a Positive Attitude

Taking a positive attitude is a component of northern women's hardiness in that it illustrates the commitment that some northern women have to making a life in the north. In addition, by taking a positive attitude, northern women are attempting to exert some control over their situation, and purposely seeking to view challenges in the north as positive rather than negative. Many of the women in the study spoke about how they needed to purposely develop a positive attitude toward living in the north. In other words, they needed to "work at" developing a positive attitude, as Carmen explained, "When you live in...more remote areas, you have to make yourself be positive. It's not something that just happens."

The women used various strategies to develop a positive attitude. Not dwelling on the negatives helped women ignore or downplay problematic situations and focus on more positive opportunities. Carmen, a woman in a small community who finds living in the north problematic, explained, "You have to have an upbeat positive attitude. What makes you hardy is the fact that you don't dwell on the fact that you're living where it's cold and remote". Downplaying the negatives also included "[having] something to look forward to...getting away from it [the north] once in a while", Carmen explained. Amelia, who lives in a very small community several kilometers from a major center, stated, "I try not to dwell on it [isolation] too much". Rather, Amelia focused on what was available and on developing interests that were feasible in isolated environments, such as gardening and enjoying farm animals. Developing a positive attitude also required that one accept the limitations of the north, as Lilac declared, "If you choose to live here, then you adapt. You put up or make allowances for the lifestyle". Barbara, a northern woman who early in life wished to move out of the north for more urban amenities, noted that she has "become comfortable with what the area has to offer", that "rather than fighting that [northern negatives] and trying to make it [the north] something that it wasn't, I've become more accepting of it and certainly I appreciate it more". In short, for some women, a positive attitude was fostered by not dwelling on, accepting, and adjusting to the limitations of the north.

Laughter and a sense of humor were seen as excellent, indeed vital, strategies to help women develop and sustain a positive attitude. Christine advised that one should "try and be happy about your life. It's amazing what laughter will do". Casey also noted the importance of a sense of humor:

> You just *have to have* [her emphasis] a sense of humor because otherwise you wouldn't survive...It's just so frustrating sometimes on these places [ranches] when you get one step forward, two steps back and you're wet or you're freezing cold or your whole day's just been shot because something's gone wrong.

Sharing laughter with others was a source of support and helped put setbacks and challenges in perspective, thus contributing to a positive attitude. Other women spoke of surrounding themselves with positive people. Marie tried to "focus on and be part of the lives of positive people" in forming friendships that would sustain her positive attitude.

The ability to take a positive attitude is affected by several factors. The weather is a major influence on the attitudes of northern people. Cool rather than warm summers and long cold winters require one to put more effort into staying positive, as Carmen explained:

> You can't just let the weather dictate to you what kind of mood you're going to be in. It's difficult sometimes, because like lots of times I have to really make myself be positive and not let it get me down.

Because challenging weather and distance may prevent access to support from others, women may need to depend primarily on themselves to be happy, as Carmen explained, "As far as women in the north, you have to be, in some ways, a different breed...You have to really be able to uplift yourself". Carmen noted that the threat and the reality of job loss in the north compounds the difficulty in taking a positive attitude, "That adds to it, certainly. Then you have to be stronger and have to really find ways to keep yourself thinking healthy [and] happy".

Personal expectations also affect women's inclination and ability to develop a positive attitude. Realistic expectations about living in the north help to maintain a positive attitude and to avoid disappointment, as Alice explained, "If somebody comes and lives out here and says, 'Well, I don't want any dirty hands or I don't want the muck and the mud and the smell of the cows', well, then they shouldn't do it [move to the north or to a farm]". Rhoda also noted the importance of having realistic expectations when she stated, "What are your expectations of coming up north? What do you think you're going to find here? Some people think that they're going to find the wild west and it's not being realistic". Moreover, negative attitudes or expectations about life in the north may hinder the development of more positive attitudes, as Carmen explained, "Don't move with the idea that I'm going to hate it because it's small. Get that attitude right out of your head to begin with. Because if you don't, you're never going to be happy there [in the north]". When expectations are realistic and positive and a definite choice to be in the north is made, people may be more likely to maintain a positive attitude, which better equips them to deal with the physical and social challenges of the northern environment.

Following Spiritual Beliefs

Spiritual beliefs helped northern women become hardy by helping them to feel socially connected and to maintain a sense of control in challenging situations. Spiritual beliefs also helped women to take stock of their situation and express appreciation, and to find acceptance and meaning.

Spirituality was seen as existing both within and outside of traditional religious beliefs. Rhoda stated, “When I pray I thank the creator for giving me all of these things...it’s not religious, it’s spiritual. Religious is dogma, control, dictatorship, manmade. Spirituality is about freedom, about lightness, and acceptance, and flowing with the river”. In addition to acceptance and appreciation of one’s life, spirituality gave some women the peace of mind to accept challenges in their lives, to develop control in unsettling times, and to live in happier more tolerant frames of mind. Signe explained:

> I find it’s not hard to accept the blows in life...I’ll just sit down and pray. I read the 27th and the 100th Psalm[s]. They really bring peace to my soul...I think as long as your mind is at peace - it’s when you start stewing...that’s when you start getting sick...

Thus, spirituality, both within and outside of religion, helped some women to deal with stress and to prevent tensions that could contribute to illness.

Spirituality also provided opportunities for cultural and social connections. These connections could promote the development of hardiness by providing meaning and social belonging. Aboriginal women in the study appreciated cultural spiritual beliefs such as sweat lodges, consultation with elders, the medicine wheel, and sweet grass and other ceremonies and rituals. Gert stated, “the sweat lodge - that’s where I go to church”. Aboriginal spiritual rituals put women in touch with their culture and with people of like mind who could support them. Some women enjoyed “the social aspect of it [their spiritual communities], that’s where they meet people and have a sense of community” [Marie]. For Margaret, the social connections with her church were particularly important after her stroke, as the church provided a purpose and a place for her recuperative energies.

For women who valued expanded roles for women and socialization outside of conservative religious communities, spirituality was achieved by developing friendships with like minded women, by personal reflection, and by communing with nature in walks and other outdoor experiences. The beauty, pace, and organic way of life of the north can be spiritually inspiring and refreshing, as these comments illustrate: "I'm very much into women's spirituality. I love being in the company of women...And there's a lot of access to real awesome beauty in this province and that helps me stay healthy" [Gert], and "communicating with nature, the smell of the sun on the forest floor, the trees singing in the wind,...it was just so easy...I had such a stressful childhood. So to get away from all that up here, it was peaceful" [Signe]. Thus, the physical and sociocultural aspects of the northern environment can be sources of spirituality that foster interest, meaning, and strength - important attributes of hardiness.

In summary, spiritual beliefs helped women deal with adversity to become hardy and resilient. Spiritual beliefs helped women find meaning and maintain balance in their lives. Spiritual beliefs and actions also helped women socially connect with people and provided a sense of peace, care, and belonging. Women in the study selected for themselves the type of spirituality that best met their values and their life situations.

Developing Fortitude

Developing fortitude for northern women meant developing an inner strength to help them deal with the demands of the north. This inner strength also enabled them to develop the physical strength needed for life in the north. Developing fortitude for life in the north may require developing attributes of a "warrior woman", as Eileen described:

> fierceness in battle, loyal to your friends, know how to survive in the bush, you have to have the heart to keep on going...even when you're wounded, an inner strength or fortitude to carry on in the bad and the good times, to always be a little bit in training - you can't get too soft.

Women in this study developed fortitude by *being committed* and by *learning from previous experience*.

Being committed

Being committed to being in northern environments is perhaps one of the most important attributes in the development of fortitude. Commitment is the motivational force of hardiness. If one is committed to being in the north, it may be easier to adapt to the challenges of the northern environment. For example, Alice's strong desire to live in the north keeps her motivated and "that motivation helps me keep going". Alice moved with her family from Europe to start a farm in northern BC. For her, choosing to be in the north greatly facilitated her commitment to be in the north, as she stated, "Everybody has to choose their own lifestyle...motivation helps me, it keeps me going [here, on the farm]". In addition, elements of living in the north, such as its beauty, the slower pace, and the opportunity for outdoor recreation, may be seen in a more positive and supportive light if one is committed to living in the north. Alice's strong commitment to living in the north is revealed in her positive perceptions about opportunities in the north, "You can go swimming, you can go tubing down the river, you can go horseback riding, we have so many options". Viewing these opportunities positively may help to balance northern negatives. Committed northerners, then, may be better able to develop the fortitude required for life in the north than those who are not committed to living in the north.

Choice seems to be important in the development of commitment. For example, Alice spoke repeatedly and forcefully about the importance of choosing to live in the north. She noted that the weather and other 'negatives' of northern life were of little consequence, largely because she had chosen to live here:

> The motivation and the desire to do it [move to northern BC] was so big that it [her life in the north] is a combined thing [work and fun]...when we acquired the cows, come winter when we have to feed them, [when] we have to help them calve and shift them from one pen to another - it is motivation, fun and work...I really love it...it gives me lots of pleasure....Again, I think it comes down to choice.

Indeed, some elements which were seen by some women as negatives, such as isolation and solitude, were, in Alice's estimation, positives, attractions to the north from the busy crowded existence in Europe.

For some people, choice is not a viable option. Rather, the north is quite simply where they must live due to employment or other factors. Nevertheless, over time, women may come to prefer life in the north. Barbara, a woman who was raised in a small northern community "used to think I wasn't as proud of the fact that I was from a small area". However, she stated that "now I prefer it...the peace and the quiet...I've become more accepting of it and I appreciate it more." Coming to appreciate and prefer the north may lead to greater commitment, as Barbara's experience illustrates. Over time, she has become very active in community organizations and events that advance her community. These comments by Alice and Barbara indicate that commitment to living in the north can exist before moving there or it can be acquired.

With commitment comes a greater capability to accept and deal with adversity. In addition, commitment fosters receptivity to opportunities in northern environments. People who are committed to and happy where they live may be more able to facilitate their own as well as others' well- being, as Christine intimated, "If you're not happy with your life, you're not going to help other people". By being committed, northerners are able to enjoy a greater quality of life within the confines of the north, and they are better able to develop the fortitude necessary in northern environments.

Learning from previous experience

Knowledge of the physical and social characteristics of the north helps women to anticipate and develop appropriate fortitude for life in the north, to endure dangerous and adverse situations in safe and effective ways. Women in the study acquired this knowledge from their own and others' previous experience in northern as well as non-northern settings. For example, Lillian, who had moved to northern BC in 1924, was not daunted by her or her husband's need to drive in winter because "he's [her husband] grown up with it [snow and icy road conditions]. And so have I". Several women appreciated the value of dependable transportation in northern environments because of their previous experience in northern settings. Jocelyn, who had lived in northern Ontario before moving to northern BC, made the decision to purchase a new four wheel drive vehicle so that she would have reliable transportation from her country home in winter weather. Marie, who had also lived for several years in northern BC, recommended that women "should be prepared to drive a truck (laughter). Unless they're just going to putter around in the city all the time". Previous experience helped these women make decisions and take actions about transportation that would give them peace of mind; they knew that they would be able to access goods, services, jobs, and other resources in distant locations and during inclement weather.

Having previous experience can help women plan ahead for dangerous and challenging situations. This anticipatory planning helps women encounter adversity with courage and strength. Based on her experience living in the north, Casey provided a list of recommendations regarding knowledge, skills, and resources that northern women should develop or access:

> keep a dog to alert you of approaching company (human and wildlife), inform yourself of wildlife in your area and take recommended precautions (eg. carry pepper spray), subscribe to BCAA for roadside assistance, have a cell phone, always have proper footwear and warm outer wear in your vehicle, vehicle maintenance is especially important in remote areas and a good set of tires goes a long way towards road safety, know basic first aid and keep a first aid kit in your home and vehicle, have a back-up plan for food and heat in case of severe winter conditions (power outages, roads closed, etc.)...

Northern women also develop fortitude by learning from the experience of others who have lived in the north. Eileen remarked on how family who had lived in the north facilitated her re-entry into the culture and mores of a small northern community:

> When I first moved here, my mom said to me, "You'll have to learn to watch your tongue. It's a small town you know". Because she lived here a long time...She knows [that] life can be made quite difficult for you by the alliances

> about the town - if they're against you, if you're on the wrong side.

Casey commented on the importance of role models who helped her learn about ranch life:

> One of my closest friends - she grew up in the area. She's very strong. She gave me some techniques for chopping wood...I've learned an awful lot from her and other neighbors...how to raise a meat bird and gut it and clean it and - well my husband helped me - how to throw a bale of hay. There's a lot of technique to this stuff and you just start to learn.

Having fortitude can also help northern women develop physical strength and independence. By having fortitude - an inner strength - northern women have the courage to develop the physical strength they need to deal with northern weather and roads, as well as with outdoor work and leisure activities. Women with fortitude in rural areas are better able to develop the physical strength needed to safely and effectively look after animals, keep wood stoves supplied and operating, and operate heavy equipment such as tractors, plows, and snow removal equipment. For example, Rosie, a woman who lives in a very remote location, noted that "women in the north do a lot of what's considered men's jobs...carrying water, cutting wood, stoking fires, cleaning barns, running a cat or a tractor". Rosie felt that having the strength to engage in these tasks "makes a woman feel more independent".

The longer women have lived in northern isolated settings, the greater can be their confidence that they have and can develop the commitment, knowledge, experience, and physical strength necessary to endure dangerous, adverse, and challenging situations. As Elizabeth stated, "Once you've been there a while and survived through a couple of winters, you know you're ok and you're going to make it...you can do it".

Establishing Self-Reliance

Hardiness of the women in this study was also revealed in their ability to establish self-reliance. This meant taking responsibility for themselves and their health. As Barbara stated, "Health is your own sort of personal journey and I think a lot of people have to take more responsibility for their own health".

Self-reliance requires that northern women be able to access needed resources. Self-reliance was demonstrated by planning ahead to accommodate constraints imposed by the physical environment and limited resources. For example, women purchased in bulk when shopping in distant locations, and stocked up on supplies for winter to decrease the need to travel in inclement weather. Marie noted that one of the reasons she has a truck is so that she can bring supplies from distant communities for herself and her neighbors. Resources such as enhanced communication technologies have also helped women establish self-reliance. For example, they are better able to make timely arrangements and stay in touch with others. Amelia noted:

> Now in most places there's a telephone, you can stay in touch, you can make arrangements. When I was [lived] there without a telephone, I didn't go visit someone that I might have because I didn't know if they'd be home. And it was like a major journey to get ready, go, be there, and then if they weren't home, you're back again. So [enhanced] communication has certainly helped.

Establishing self-reliance included developing new or enhancing existing abilities and skills to counter isolation and limited options. A northern woman must learn to rely on herself for entertainment and support, particularly in winter, when getting out and being with other people is often curtailed by weather and road conditions. Lilac noted, "Have things to keep you amused at home because there are times in the wintertime when you can't get out". Elizabeth learned how to suture so that she could manage acute injury situations in remote locations. Rosie, a nurse in a very remote location, is the only local source of health care. To enhance her abilities to provide care, Rosie is returning to university to obtain her degree in nursing. Rosie's self-reliance is especially important during inclement weather, when it is impossible to telephone out of the community, leave the community for care, or bring into the community needed resources, such as an ambulance or helicopter to remove an ill or injured resident.

Learning to drive was for some women a significant personal achievement that fostered their self-reliance. Learning to drive provided freedom and the ability to acquire needed resources without having to rely on husbands, friends, or neighbors. However, learning to drive was not always easily accomplished, as Lilac described:

> I finally learned to drive just before my fourth child. I had driven a tractor before but every time I went to learn to drive, I would get pregnant again, so I'd wait and I had one [a pregnancy] every three years so I finally got desperate and learned to drive.

Being self-reliant then is a way that northern women develop hardiness to cope with physical and social environmental conditions such as isolation and limited access to resources that make them vulnerable to risks to their physical and psychosocial health.

Although establishing self-reliance is likely a goal of most northern women, some women are less able to attain this goal due to personal circumstances. Park, a woman who works at a women's center in a small northern community, explained:

> It would be nice to be self-sufficient but if there's underlying issues that women haven't dealt with - childhood or relationship abuse, life traumas, financial lacks or poverty - it's really hard to be hardy, it's really hard to be strong. Women need to have a support system in place to become those persons that we expect.

Thus, the minimal resources in many small northern communities compromise women's ability to establish self-reliance, especially if women experience personal and social issues such as abuse and poverty.

In summary, in spite of and, indeed, because of the limitations of the northern environment, women in northern BC are able to become hardy. This hardiness is developed by taking a positive attitude, following spiritual beliefs, developing fortitude, and establishing self-reliance. By becoming hardy, northern women are better able to develop the resilience needed to endure the hardship, adversity, and danger in northern environments that make them vulnerable to health risks.

Theoretical Perspectives of Hardiness

As the previous discussion indicates, hardiness clearly emerged from the findings of this study as a significant concept. However, in the literature, hardiness as a concept is not fully developed or understood theoretically, and it has rarely been studied with female and other disadvantaged populations (Lindsey & Hills, 1992). Studies to date suggest that hardiness is a group of personality characteristics that function as a resistance or buffer to stressful life events and that enable individuals to remain healthy and to adapt to illness (Kobasa, 1979; Wagnild & Young, 1991). "Hardy" is frequently used as an adjective to describe rural people who manage in adverse circumstances (Lee, 1983).

Much of the literature on hardiness affirms that this concept involves components of commitment, control, and challenge (Maddi, 1998). People with commitment believe that active involvement leads to an interesting and worthwhile life; people with a strong internal sense of control believe that they can influence life events; people with a strong challenge component believe that a sense of fulfillment results when they learn from experiences, whether positive or negative (Maddi). These three components form a personality constellation that is an amalgam of cognition, emotion, and action, aimed not only at survival, but at the enrichment of life through development (Lindsey & Hills, 1992).

In addition to the three core components of commitment, control, and challenge, other components and attributes of hardiness have been proposed. Consolvo, Brownewell, and Distefano (1989) in their work with neonatal intensive care nurses suggested that the component of companionship may be important because it allows people to vent feelings with peers, friends, or family. In a review of the literature, Lee (1983) identified four critical attributes of hardiness: 1) endurance, the physiological and/or psychological toughness to continue; 2) strength, the ability to resist force, stress, hardship; 3) boldness, the quality of being courageous, daring, adventurous; and 4) the power to control, the ability to exercise authority or influence. Lee noted that these attributes, although distinct, are interrelated and interdependent.

Many of the components and attributes of hardiness identified in the literature are reflected in the experiences and perspectives of the women in this study. To become hardy, the women in this study became involved in the strategies of taking a positive attitude, following spiritual beliefs, developing fortitude, and establishing self-reliance. Commitment to making a life in the north and the ability to control and deal with northern challenges by establishing self-reliance were particularly salient attributes of hardiness for women in this study. Taking a positive attitude significantly enhanced northern women's sense of commitment to northern life, and their ability to exert some control over their situations. These strategies reveal northern women's endurance, strength, courage, and other attributes that comprise a hardy perspective and hardy abilities. Because so little research has been done to examine the concept of hardiness in rural and northern women, the perspectives of the women in this study are particularly important in increasing our understanding of how hardiness contributes to the health of northern women.

Making the Best of the North

In addition to becoming hardy, the women in this study developed resilience by making the best of the north. Making the best of the north means that women used and developed resources and opportunities that are available in the north. Making the best of the north enabled women to address vulnerability and risks to their health that resulted from their marginalization and from living in a northern environment. The degree to which women needed to and were able to make the best of the north was affected by the nature and degree of marginalization they experienced, personal circumstances, and women's location within the northern context. For example, women who were healthy, who lived in urban or less isolated settings, and who had adequate financial resources were better able to take advantage of northern resources and make the best of the north compared to women who were ill, geographically or socially isolated, or who did not have adequate finances.

Northern women in this study make the best of the north by *participating in northern activities, making decisions about health care services, seeking education and* *information, seeking and receiving social support,* and *working on financial and work issues*. Although not every woman engaged in every one of these activities, all of these activities were engaged in by the women collectively.

Participating in Northern Activities

Women in the study took advantage of the positive elements of the northern environment such as easy access to outdoor activities. These outdoor activities included skiing, kayaking, hiking, riding horses, golfing, fishing, and camping. Jocelyn enjoys walking, as she explained, "At this time of the year [spring], I begin walking. Last week, for instance, I walked into work and that's 11 kilometers...I plan to do that until September". Several women enjoyed gardening and playing sports such as softball and rugby. Hockey, rodeos, 4 H programs, and cattlemen's association activities are additional outdoor oriented programs in northern BC. Women participated in these events either directly or as parents or spouses. By taking advantage of these events, women enhanced their physical, social, and mental well-being. It is important to note that women needed to be physically and mentally able and have social and financial resources in order to participate in some of these demanding and costly activities.

Women also spoke about the importance of having indoor hobbies and interests because winter weather limits travel, socialization, and outdoor activities. The variety of indoor activities that northern women engage in indicates their creativity and resourcefulness in developing solitary as well as social activities to develop the resilience necessary in isolated conditions. Some of the solitary indoor activities included reading, writing, using the computer, watching TV, playing and listening to music, and painting. Indoor social activities included socializing using the telephone; entertaining friends in one's home; going out for dinner; indoor sports, such as racquetball, swimming, and curling; exercising in a local gym; quilting and embroidering; joining groups such as a history group, a writers' group, a ham radio group, and church groups; and attending hockey and other indoor sports and entertainment events. Indoor events helped women maintain their physical and mental health and social connections in spite of inclement weather.

Some women participated in activities in locations beyond their immediate communities. Linda and her family would sometimes travel to Prince George and stay at a hotel where the children enjoyed the water slide, and Linda could enjoy the amenities of a city. Carmen also traveled outside her community to enjoy other northern amenities, "we're going to a concert [in Prince George] and we're going to stay overnight and go out for dinner...we're not going far...there's still winter, but we're doing something different. It's more entertaining". If women could travel, their ability to access resources was enhanced, and their mental health could be improved. Accessing resources at a distance was particularly important in winter, when decreased sunlight and cold weather contribute to depression. A change of scene, as Carmen noted, helped women stay mentally healthy.

Women also engaged in activities that promoted the health and quality of life of other northern residents. Women often engaged in these activities as volunteers. For example, Casey and Vicki were volunteers at the local library, Elizabeth volunteered at a preschool and for the cancer society, and Signe was a volunteer with a local literacy group. Barbara had co-chaired a parent advisory council, and was presently a member of a community tourism task force and of the community economic development group. Robin was a member of the local women's group that organized fall fairs, provided meals to shut-ins, and engaged in fund raising events. In addition to being enjoyable, these activities were, as Jocelyn stated, "part of the thing that I can contribute to the community". These types of participation indicate women's commitment to supporting and enriching their communities, as well as providing women, personally, with opportunities for social interaction.

Making Decisions about Health Care Services

In addition to participating in northern activities, women in the study made the best of the north by making decisions about health care services that would enhance their health. Women weighed the consequences of whether to use a health service in order to achieve the best care possible, given the northern context of limited health care resources. The health care services that women made decisions about included *physician services, alternative health care services,* and *self-care practices.* Women's decisions were based upon several factors, including their health problem or need, women's knowledge about the service, the availability and quality of the service, experience with and support for the service from others, and geographic and financial accessibility. Women's age and their cultural and educational backgrounds also influenced decision-making about health care services.

As described in previous chapters, northern women are vulnerable and at risk of inadequate health care. Women often tried to circumvent inadequate care by seeking a second opinion from another physician, or by changing their physician. However, with the scarcity of physicians in northern communities, women were often not able to find another physician. Even when another physician could be found, women noted that it was common for this physician to refuse to accept the patient of a colleague in that community. Marie stated, "There's this kind of closed in society [among physicians] in that they [physicians] don't want to take another doctor's patient." Rhoda noted that "You're restricted about who you can see and they [physicians] all make these rules. You don't have that much freedom [to choose physicians]." Therefore, although women might wish to seek a second opinion from a physician, this was not always possible.

Another strategy women used to address inadequate care was to secure physician services in another community. If possible, a woman might travel to a physician in another northern community. However, women on a low income and women who could not travel simply put up with the care they received, rather than changing physicians. Putting up with a physician sometimes resulted in poor physician patient relationships and quite possibly inadequate care, as Fred explained, "You want to have some kind of relationship with your doctor. So how often do you say, 'Well, I think you're wrong'?"

To address the limited options of health care in the north, women made decisions to use alternative health care information and providers to supplement or replace traditional medical care. Women believed in alternative therapies as legitimate health care resources in their own right. As Barbara noted, "I think that they're relaxing and they're not intrusive, they don't harm you". To use these therapies appropriately, women investigated the nature and effectiveness of alternative therapies by consulting others who knew about or had used these therapies, and they read books and found information on the Internet. Jocelyn, for example, has "been reading more and more, trying to stay healthy. This is very, very important in my life." As a result of reading and attendance at women's health workshops, Jocelyn has decided on several type of alternative therapies such as gingko biloba and vitamin E for treatment of her menopause symptoms.

Nevertheless, as described previously, there are barriers for northern women to the use of alternative therapies. Limited resources that could help women assess the merits of alternative therapies, and the costs of alternative therapies were barriers for some women. Even if affordable, alternative health care services were often not located in northern communities. Again, distance, weather, time, and finances affected how or if women could obtain these services. To counteract these constraints, northern women attempted to increase the health care options that were available in their communities. Some women invited practitioners to their communities, as Barbara did, " I invited her [a feldenkrais practitioner] out to give a two day workshop in [our community] and...I've got information on this method". In addition, some women, such as Barbara, have themselves become alternative health care practitioners so that they can increase access by providing this care to themselves and others in their communities.

In addition to securing professional services, women often chose to engage in self-care practices to supplement or replace medical and alternative types of care. Signe, an elderly woman with a low income, addressed seasonal affective disorder by "sit[ting] there in that window [in the sun] in the morning. It is so soothing. But if it's a gray day, I'll put my lights on...I have lights on all around. I need the light". Signe also used music to alleviate the sad feelings that a dark day engenders. Several women noted the importance of good nutrition and exercise in the fresh air and sunshine as important for one's physical and mental health, especially in winter. Vicki stated, "Well, in the north, if you don't do winter sports you become a vegetable from November to March so I'm very outdoorsy in the winter." Mary and Gert, two Aboriginal women in the study, explained that Aboriginal women may consult elders and use sweat lodges, herbs, and sweet grass and other ceremonies to facilitate health and healing. Gert explained:

> I have a real strong connection to herbal medicine...I found remedies like herbal remedies and I started looking at how to heal myself...I started reading and I asked some of the elders [and] I've had medicine from elders...And it felt like, 'This feels right! This feels good!'

Women valued having choice and options in health care. The ability to choose a physician or another type of health care provider as well as to select which services to accept from a provider were highly valued. Ultimately, women in this study expressed a desire to be what Rhoda termed a 'wise woman', "A wise woman knows her own body, takes time to research methods of healing...[is] a support. She also has...herbs and natural healing stuff so she's a very wise woman - a crone". A range of respectful and affordable health care resources, both traditional and alternative, that foster the creation of empowered wise women were seen by the women in this study as important for increasing their options and access to health resources, and thus for the promotion of their health.

Seeking Education and Information

Women in this study highly valued education and information for the knowledge, skills, and attitudinal changes they could provide. Women sought education and information from formal and informal sources such as *universities and community colleges, nurses and physicians, community education programs,* and by using *distance education*. Education and information enhance northern women's health by increasing their job and career opportunities and access to health care, helping them leave abusive situations, and enhancing their quality of life. The strategies used to obtain information varied with women's circumstances, such as their degree of isolation and the financial, educational, and other resources that were available.

Universities and community colleges

Some women sought education at universities and community colleges because they felt that such education would enhance their quality of life and advance their abilities in their workplaces. Eileen stated that education "exposed [her] to new ideas" and helped her feel less culturally, socially, and intellectually constrained and isolated. Consequently, in keeping with her value of education, Eileen was completing a Master's degree. Gert was planning to begin a Master's degree to help her be more effective in her counseling job. Rhoda and Rosie were enrolled in baccalaureate programs to enhance their abilities to educate and support others. Rhoda felt that a degree in gender studies would assist her in her counseling position, and Rosie was completing a baccalaureate degree in nursing as a way to enhance her abilities to provide nursing care in the remote community where she lives. Young women such as Leah and Ruhi seemed to value education primarily for its ability to facilitate career goals. Consequently, Leah was a university student, and Ruhi was enrolled in a local community college.

The value of university education was very evident in the perspectives and behaviors of women in this study. Even if women did not attend university, many of them still contributed money to the building of the University of Northern British Columbia, the only university in northern BC. Although the women saw UNBC as important for their children and grandchildren, some women, such as Rhoda, surprised themselves by becoming university students late in life. Rhoda stated, "I put a lot of money into getting this university going. Never thinking I'd be going. I did it for my friends' children". Nevertheless, access to university education was deemed important for adults, too, as enrollment in university programs by several women in this study attests. However, as indicated in Chapter V, access to UNBC programs is very limited in northern BC, due to the limited resources available to provide courses and programs in small communities.

Nurses and physicians

Women contacted nurses for advice about health issues and for recommendations for referrals for care. Nurses were valued for their knowledge, approachability, dependability, honesty, respect for women, and for their willingness to listen to women's concerns. Vicki found that "if you want to find out where the good doctors are, you ask a nurse." Eileen noted, "I would like to see a lot more nurses because...you get more time and more education [from them]." Rosie agreed that nurses are a valuable source of information:

> there needs to be more available for women...better if it was a nurse because nurses are deemed approachable, they're a woman... You could talk to her about a holistic approach to health...Having some[one] that you can understand and deal with. I think that's really important for women in the north.

Vicki felt that nurses "give me the time that I need to be able to evaluate what it is that I have been told [by a physician]" and that nurses could "sit down and look at research and pass it on" to patients. Nurses provided information, clarification, and advice that helped women make decisions and interact more assertively and fruitfully with physicians and other health care providers. However, the limited numbers and restricted roles of nurses in northern communities compromised the amount and quality of care that northern women could receive from them.

A few women actively sought health information from physicians. Alice stated, "I am on the case on my doctor. I really strongly sit down with him and I make him sit down to talk with me about every step". Fred, a woman with multiple sclerosis, stated that "as the main person, I want somebody more educated than I am...the primary guy is the doctor...when I want a diagnosis, I want a doctor's diagnosis." Vicki, Jocelyn, and Rhoda consulted physicians for advice about menopause symptoms. However, as pointed out in the marginalization and vulnerability chapters, not all physicians are receptive to women's assertive behaviors and their desire to be informed partners in their care. In addition, some women discovered that physicians may not be knowledgeable or supportive about some issues, such as alternative therapies or menopause symptoms and treatments.

Community education programs

Community education programs were highly prized by many of the women in this study. These programs were geographically accessible and, thus, required less time and financial resources to attend. Women in the study attended community education sessions on menopause and breast cancer; these sessions were arranged by public health nurses and staff at women's centers. Women also used resources at the local library and the women's center, if one existed in their community. In addition to being valuable for information purposes, community education programs had other positive effects. Jocelyn, a social services worker in a small community, explained that access to local education facilitates social support for some of her women clients:

> A wonderful escape hatch [out of abuse situations] was schooling, education, and a lot of women go back...at school they are going to meet other women like themselves and strength adds to strength and there will be social support for them through this.

Rhoda believed that locally accessible education helps women in abusive situations to "open their minds and see what they're giving up", and to picture alternatives and ways out of difficult situations. However, Mary noted that for some women, especially those in low-income situations, there may be a limited window of opportunity when these women could access education, as money for tuition and family support for child care may only be available for a short time. Thus, as valuable as local community education programs are, they must be provided in a timely manner, and with supports such as child care and travel subsidies to facilitate the attendance of women with children, low-income women, and women who live in rural areas.

Distance education

Distance education was a viable option for some women, especially if they were geographically isolated or had family and other commitments. Correspondence school was one way that Carmen thought she could access needed education in her remote community. Some women, such as Mary, valued distance education because it fit with their lifestyles:

> I took the distance education course and graduated with my Bachelor of Social Work degree, working part time, studying part time, and being a mom full time. After that...I enrolled in the satellite program and took my Master's degree...all while my children were growing up and still working and being a full time mom.

Casey noted that "more affordable satellite dishes and Internet access are facilitating distance learning". In addition, some women engaged in distance education by traveling from their northern homes to educational institutions elsewhere in the north (such as UNBC in Prince George) and outside the north (such as UBC in Vancouver). However, in order to take advantage of distance education, women needed to have adequate resources such as finances and time so that they could purchase equipment or travel to required sites.

Northern women in this study highlighted education and information as key cornerstones for their health. Education helps women to develop resilience by enhancing their personal capacity to access and use resources, which can minimize health vulnerabilities. More attention to northern women's education needs and barriers to education would promote the health and quality of life of all northern people.

Seeking and Receiving Social Support

Women in the study felt that social support was central to their health. All types of social support were evident: instrumental, emotional, affirmational, and informational (House & Kahn, 1985; Stewart, 2000). Instrumental (practical) support facilitated women's access to goods and services. Emotional support provided assistance in coping with the isolation of northern physical and social environments. Affirmational social support helped northern women claim their decisions and actions as effective and appropriate. Affirmation was particularly important in northern environments where women's ideas and behaviors were ignored, dismissed, or otherwise undervalued. Informational support has been discussed in the preceding section. The remaining types of social support - instrumental, emotional, and affirmational - form the basis of the discussion in this section, which will address *unique aspects of social support in the north, functions of social support,* and *sources of support.*

Unique aspects of social support in the north

The northern physical and social environments present some unique aspects of social support for women. Physical and social isolation, limited options, and undervaluing of women increase the need for social support for women in the north. Marie explained that "there's this macho sense, this male camaraderie, and it excludes women and I find up here women tend to group together and be more supportive than in other places". However, women who are seen as outsiders by the community, such as women who are new to a community, may experience greater social isolation, and may not be accorded the social support that would help them in isolated northern environments (Bailey, 1998; Lee, 1998b). Sources of social support may also differ, as frequently northern residents have left extended family to seek employment in the north. Thus, friends often take the place of family in the north.

On the other hand, there are also barriers to seeking social support that are unique to the north. There are few formal resources, such as support groups, and these may be more difficult to access, due to lack of transportation and child care, and inclement weather. As discussed in the chapters that addressed marginalization and vulnerability, lack of anonymity and risks of breaches of confidentiality may also hinder women in small communities from seeking social support in public places. This is particularly true for those women with mental health disorders due to the stigma that exists about these types of health issues in small communities. As a result, some women may forego seeking social support if their identity could be revealed. For example, Eileen explained, "The mental health [building], it's a hard place to make yourself go into...what will people think I'm here for?". Eileen suggested that the use of mental health services would increase if these services were offered in a building with other services to increase anonymity.

In short, the northern context leads to a greater need for social support, while also making problematic women's abilities to meet this need, thus increasing their vulnerability to psychosocial and physical health risks.

Functions of social support

The importance of social support, particularly in extremely isolated settings and during isolating winter weather conditions, cannot be overrated. Emotional support is essential in helping northern women to address their vulnerability to psychosocial health risks, such as loneliness, boredom, and depression. Carmen explained the importance of getting out and being with other people:

> If I feel like I don't want my own company - even if I don't sit with anybody, I can go downtown, have a coffee, and there's people around. I would find it really hard to live in a place where I couldn't go out and see people...just to know there's other life around.

Signe noted that it's important "to find somebody to talk to, to ease the loneliness or the long dreary winters". Carmen emphasized that even one close friend can help decrease the isolation of northern life, "If women have a close friend, even one closer friend, that they could talk to, they don't feel so isolated".

Some women sought support to maintain a sense of belonging and cultural and historical connectedness. For Mary, an Aboriginal woman, maintaining contact with her sister keeps her connected to cultural traditions and values and to friends and family who live far away:

> she relays a lot of the cultural things to me...she speaks the language, she is living in the culture [in Alberta] and I'm kind of over here [in BC]...she'll talk about the sun dances and the give aways and there's different weddings happening in the family. And she says, "We need to go to those things. These are important". I like to hear those things.

Instrumental support was important to help women with practical tasks and physically demanding work such as caring for animals on the farm and shoveling snow. In addition, some women helped others obtain goods and services from afar, as Rosie explained, "That's another thing about living in a small northern community. When people go out of town shopping, they always tell their friends and ask, 'Is there anything you want me to pick up for you?'"

Instrumental support in the form of financial assistance is also important for northern women's health and quality of life. For women living in low-income situations, financial support in the form of gifts can be helpful, as Signe, an elderly low-income senior, explained, "A lot of my friends for a birthday will give me a gift certificate to Crafts Canada or to Overwaitea [a grocery store] which is always graciously accepted." Lilac and Lillian, two elderly women, appreciated the financial support from families who lived nearby, and who provided transportation, meals, and other types of day-to-day support which augmented these women's incomes.

However, financial security that is enabled by support from friends and family can highlight women's dependency. For northern women who have been independent, becoming dependent is difficult and a threat to their self-esteem, as Signe explained:

> I've done everything for myself for so long...This last little while I have to phone people to do things for me which I've never done...It's humiliating...I raised my two girls for many years on my own...I held down two jobs and rented rooms to make ends meet. I never asked for a dime from anybody. I guess that's what you call false pride. I'm very stiff necked when it comes to putting your hand out to charity. I don't want to do it.

Fred, a woman with multiple sclerosis, noted the importance of reciprocity in relationships when she said, "if you do it [take friends up on their offers to help] all the time you aren't a friend on an equal basis anymore. I think you become a dependent and I don't like that position". Women in the study would seem to prefer social support that helps them maintain their independence, rather than support that confronts them with their dependency.

Both instrumental and emotional support helped northern women deal with physical and mental health issues. Friends helped some women develop confidence and courage and assisted them in obtaining information from health care professionals.

Leah, a young woman with obsessive compulsive disorder, found that taking a friend with her to physician visits was beneficial because "it can make you less intimidated to talk to the doctor. I think it just makes you feel more in control... And maybe they're [the friends] going to ask questions you might not think of...to help me make decisions". Robin, too, believed that her recovery from cancer was greatly facilitated by the support of friends and family, "I've battled cancer twice and I think both times if it had not been for the fact that I believe that being connected to other people is healthy [I wouldn't have survived]". Signe's physical health was also supported by friends who brought groceries and helped with housework. These instrumental supports helped Signe keep a positive perspective and stay physically and emotionally healthy, as she explained:

> Without them [social supports] you'd be in trouble. But I have good backup, good support. Like my doctor and my friends, and this embroiderers' guild I'm in...There's always somebody [contacting me] - one of the girls has adopted me like a mother - she phones me very day...And I find I'm interested in life."

Gert attributed much of her recovery from a heart attack to friends and family who provided a place for her to stay during her hospitalization in the lower mainland, and who visited daily during her recuperation.

In addition, social support enabled northern women to compare and contrast their lives with others. Social comparisons help people answer four questions: What is happening, and is it serious?; Is it normal?; How am I doing?; and, What should I be doing? (Aspinwall, 1998). Two types of social comparisons exist - downward and upward. Women in this study used both types of social comparisons.

Downward social comparison, in which people identify areas in which they are relatively advantaged compared to others, helps people make the best of a difficult situation and regulate emotions (Aspinwall, 1998). By comparing their lives to others, some northern women found affirmation and perspective and, thus, were better able to deal with issues such as poverty and lack of access to health care. For example, Linda, a low-income mother of three children, noted, "sometimes you look and say, 'Wow, look at her life compared to mine. She's a lot worse off than I've been'". Signe gained perspective by comparing herself to someone she felt was less fortunate, "I don't feel slighted because I'm not the only one [waiting for surgery]. I have a friend who's waiting for a heart transplant. She's been waiting for over a year. So she's worse off than I am."

Upward social comparison, the comparison of oneself to people who are adjusting better than oneself, can provide important information about how to do better, and may also serve as a source of hope and inspiration (Aspinwall, 1998; Taylor, Buunk, & Aspinwall, 1990). Rosie believed that interaction with others provides opportunities to learn new and better skills and to develop a sense of hope:

> ideas...and things to do and new ways of looking at things...[and] some skills to deal with this...another way to look at this...from someone who says, "Hey, I've been there, done that, it's not the end of the world".

These types of comparisons helped northern women gain advice, information, skills, emotional equilibrium, perspective, and hope.

Sources of social support

Because people often move away from family to the north for employment, family members are often not close by. Although northern women maintain contact with distant family members by telephone and by visits, the challenges of the northern environment and the lack of family and other supports necessitate the development of new "family" surrogate networks. In the absence of family, northern women often found that friends become like family. Gert stated, "the friends that I have here, the support network, the family we've created here help me stay healthy". Rhoda "came out from Ontario from a huge extended family, came by myself, and you make your family". Rosie noted that one of the reasons friends were trying to move to her community is because "they really like the feel of the community here. It's like an extended family".

Support from women was particularly valued as it affirmed women's experiences, and helped women to deal with the isolation they experienced in northern communities. Women shared common experiences and perspectives, as Alice explained:

> By interacting with people, especially women, they respond to you in your similarities...if I as a woman have certain problems, I'd love to share them with other same age group women to see what they think, what kind of experience they went through.

Carmen agreed that "no matter how good of a relationship you have with your husband, there are times when you need another woman to talk to...women can be more candid with each other". These comments indicate that social support from women to women can provide support that affirms women's experiences. Affirmational support may be particularly important for women in northern settings because of gendered norms and roles, and because contact with other women is limited.

Women also sought social support through group endeavors. Faith communities were identified as important sources of social contact for several women in the study. Women also participated in hobby and craft groups such as an embroidery guild, book clubs, and writing groups. Casey noted that the high prevalence of service clubs, sports teams, and other interest groups in her community "might indicate a recognized need for rural social interaction". Self-help groups such as a group for people recovering from strokes, and groups for specific physical and mental health issues were helpful for some women. However, as indicated previously, due to the uniqueness of their needs and interests and the sparse population, some women found that self-help and other groups were not available or useful options in providing social support. For example, Eileen noted that "if you're any kind of artist, life here feels very constrained in terms of not having like minds".

Social support, then, is of vital importance to northern women. Women in the north have to work at maintaining their existing connections, and they also need to develop new social connections. Support helps women address mental and physical risks to their health in a northern environment that is characterized by social and physical isolation and that has limited options. Perhaps Signe summed it up best when she said:

> Times have been real tough here when there's just been nothing come in and you have to survive. Well, you talk it over and you get ideas from each other. You learn to cope... [If you] get stressed out and [you] don't know how to find help...[if you have a] stiff upper lip, that can kill you, that stiff upper lip.

Social support for women in the north has allowed them to receive and offer practical, informational, affirmational, and emotional support, all of which assist them to develop resilience in facing the challenges of northern life. Clearly, as the women in this study have indicated, northern women are happier and healthier with social support in their lives.

Working on Financial and Work Issues

Women in this study engaged in work of various types and for various amounts of remuneration, including no remuneration. Women worked to support themselves, their families, and their communities. Work and financial security were critical in the development of resilience to counteract the vulnerabilities experienced due to the limited goods and services that are available in the north. With adequate finances, women could better access goods and services that are not publicly funded or that were available at a distance. Thus, financial security fostered women's physical and mental health in challenging northern environments. In this section, I discuss *the nature of women's work in the north*, including strategies used to attain employment. This is followed by a discussion of the strategies of *managing financial insecurity* and *managing employment-related problems.*

The nature of women's work in the north

Women in this study worked in various types of paid employment. These included farming, ranching, teaching, nursing, foster parenting, social services, retail, housecleaning, and catering. Two women were writers and one woman was a marriage commissioner. Seventeen of the 25 women were financially remunerated for their services. Work included both full time and part time employment. In addition, women worked as wives and mothers, and in homemaking activities; women were not financially remunerated for these activities. Six women were university or college students. At least 10 of the women were engaged in more than one role; e.g., they might be a mother as well as a worker and/or student. Four women in their 60s, 70s, and 80s were retired.

Eighteen of the 25 women worked in a volunteer unpaid capacity. Examples of venues included public libraries, a Women's Institute, the Society for the Prevention of Cruelty to Animals, self-help groups, church organizations, and children's groups such as sports teams and Girl Guides. Volunteer participation provided the women with an opportunity to support and strengthen themselves and their communities. For example, Signe is a tutor for a woman with mental health issues. Although Signe has several physical and emotional issues herself and is increasingly isolated and home-bound due to her disabilities, by volunteering she was able to foster her health, "I never feel sorry for myself. I'm too busy doing something else. I keep busy." Volunteering helps Signe keep mentally, socially, and physically active within the confines of her home. Jocelyn finds volunteering is a good way to balance the stresses and strains of her work:

> I'm very cognizant of the stress and strain that my work imposes...it takes its toll. So I try to balance this with something else...I'm a commissioner. I sit on the board and go to once a month meetings.

In addition, Jocelyn valued her many voluntary activities as a way to give something back to the community, "I consider it part of the thing that I can contribute to the community".

Northern women viewed both paid and unpaid work as important for promoting health and preventing illness. For women on farms and ranches and in remote areas, the physical nature of farm work helped some women stay physically healthy, as Alice explained:

> If I have to check the cows and if I have to walk all the way back to the pasture...whatever I do, whatever weight I carry, whatever movement I do will be beneficial to prevent [the severe osteoporosis that afflicted her mother].

Some women stay so physically healthy as a result of living on the farm that they win awards for physical prowess, as Robin proudly stated, "My daughter attributes the fact that she became a world class arm wrestler [to the fact that] she had to heft bales of hay. She actually won a world competition in Moscow in arm wrestling".

Work was also health promoting because it was psychologically fulfilling and empowering. Interestingly, this work often involved assisting women, personally and collectively, to alter negative attitudes and behaviors. Rhoda, a woman recovering from alcoholism, noted, "It's [work] just empowering...Work here is my (AA) program. I work with women with alcohol and drug problems all the time and that just keeps my awareness". Although Mary had two jobs in addition to family responsibilities, she felt that her work counseling Aboriginal women is "probably what's kept me going because I'm going out and seeing these different women and it feels good to try to make things better". Rhoda, a counselor at a women's shelter, also felt that "my work is so fulfilling because it's with women and it's helping women change, supporting them, giving information about violence and control issues. And letting them make their choices and supporting them." Gert, a counselor, noted:

> "I have the best job. I love working here...a big part of the work is changing that [sexism, racism, redneck attitudes]...The most important thing is that we just keep connecting, building, strengthening, reaching out to women who can't reach out to us...We [women] are the experts on who we are, on our health...we have the power. We are all different...If we bring that together and honor that in one another then we can change."

The importance of satisfying work is further reflected in the comments of those women who were not able to work. Carmen noted that "there's nothing like having a steady pay cheque to make your life a whole lot easier. And your outlook on life a whole lot brighter too". Without money, northern women are hindered in their ability to purchase goods, services, and other resources that help them maintain their physical and mental health. In addition, having satisfying work, feeling like one is contributing, and being acknowledged as making a valuable contribution by being paid are important to the maintenance of a sense of self-worth and self-esteem. Fred, a nurse with multiple sclerosis who is unable to work, aptly summarized these feelings, "I'd rather work because then I'd feel productive - I'd feel useful. I'd be doing something. I'd be somebody...You know, you sort of are your work. Before I was a nurse...and now I am a nothing".

The physical environment of the north presented barriers that influenced the type of paid work chosen and led to innovative strategies to create gainful work. Commuting in winter weather was sometimes a factor in the types of work women selected, as Carmen stated, "I would not want to commute a long distance 'cause I do not like driving on these roads in winter time...it's just too stressful. I'd rather find something around here or create something for myself". Casey also noted that winter driving conditions and the presence of large logging trucks on the highways were factors in her decision not to commute the half hour from her ranch to a job in town. For safety reasons, then, Carmen and Casey developed their own employment. Carmen developed a successful catering business. Casey capitalized on her abilities and resources in several areas of self-employment:

> I have a computer at home and I've got a background in printing and publishing and bit of graphic design so I've done labels for honey. I'm helping a friend do a seed catalogue. Babysitting...baking...I give away a lot of eggs. And we have hay.

Casey noted that "there's a healthy barter system in the Cariboo...especially with agricultural exchanges - it favors sharing equipment and it really works well, so there is that sort of communal living". Sharing of goods, services, and "a little thank you or a case of beer" helps northern women create gainful and satisfying work and develop social support networks. Carmen's and Casey's ingenuity in developing sources of income illustrates the resourcefulness and resilience that are necessary to develop opportunities for employment for women in northern environments.

Women's status within communities could affect their employment. Women developed strategies to deal with their status in the community to enhance employment options. For example, outsider women - women not from the community - may find it difficult to obtain employment in a small community where insider women - women known and trusted by the community - may be favored. Outsider women need to "prove themselves" (Christine, Rosie), "be approachable" (Rosie), "neighborly and respectful" (Casey, Rosie), and "not be intrusive, take people as they are, know the political base of the community" (Rosie) if they are to be accepted and included in northern communities. Some outsider women facilitated work options by engaging in social connections that would foster their status as an insider and thus enhance their chances of gaining employment. Leah described how outsider women need to be persistent if they wish to be accepted and included by the community, although this is a long term process. For example, Leah noted that a "lady who was just hired has lived here for three years and she said she will wave to people on the street and [there is still no response]". Other outsider women may move away from the community if they do not succeed in become insiders or in finding employment.

Managing financial insecurity

In times of economic downturn in northern communities, women have less access to the few jobs available, and partners who work in resource-based industries are vulnerable to insecure and short term employment. As a result, the economic security of these women and their families is jeopardized. Linda, a mother of three children whose husband's work is on a brief contract basis for a mine that is threatening closure, explained:

> We sort of have dribs and drabs of money, my family allowance comes in the middle [of the month] and I get support from my ex...I mean we're never hungry but the kids don't have the goodies for their lunches and stuff like that.

Women developed strategies to cope with times of economic hardship. These strategies demonstrate northern women's resilience. Christine, Carmen, Eileen, Leah, Rhoda, and Ruhi had been or were presently enrolled in educational courses and programs to upgrade and advance their education to help them obtain jobs or jobs of better quality or suitability to their abilities and desires. However, women with children and women who had limited funding found it difficult if not impossible to return to school due to lack of child care and lack of access to funding for education. Women with physical conditions found that the requirements of educational study were often not possible due to their conditions. For example, Linda, a mother of three who suffers from fibromyalgia explained some of her financial and educational challenges and her attempts with casual work to address these challenges:

> It's discouraging for me because I think of how does my husband feel about me not being able to help support the family when we're on the verge of bankruptcy...I found [going back to school] too hard because I could only go during the times when my daughter is in school...I have started housecleaning and that's bringing in a little bit more but it's really hard on me. Hard on my back so I don't know if it'll be a permanent thing...

As a result, these women were caught in a difficult situation - vulnerable to economic risk, yet physically unable to better their situation.

Women also coped with changed economic circumstances by imposing spending restrictions on a short term or long term basis. Christine noted that when finances are tight, she spends less and tries to buy locally to support the local community economy, "[I] shop in town...you're hurting your community if you shop elsewhere...[I] spend less...stick [credit cards] away - don't use them until you've got a job again or just cut them up." For Linda and her family, her husband's loss of four days of pay at Christmas - a mortgage payment amount - would mean that "we're going to have to take an RRSP out, cash it in...It's not like we have a substantial amount of those". As a result, "Christmas will be fairly short" for Linda and her family this year.

For Signe, an elderly single woman on a limited pension, spending restrictions were required due to the increased cost of airline flights that were needed to access health care outside the north:

> [The flight to Vancouver] went up from $304 to $362...because we only have one airline now. So we're trapped...I will cut back on groceries [to obtain the needed funds], I mean, I'm not starving...you always manage but it's tight...I borrowed money and at the end of the month I'll pay it back. I have friends who

9

are very good to me.

These restrictions had an impact on Signe's health and quality of life in terms of decreased nutritional status and choices, prolonged need to endure increasing levels of pain which required increased amounts of narcotic medication, and prolonged and deeper debilitation which eventually resulted in Signe being housebound in a wheelchair. Such debilitation would no doubt prolong recovery and affect the degree of mobility that Signe is able to regain. Financial constraints and women's ability to address these constraints, then, affect women's physical and mental health in the short term and in the long term.

On the other hand, there were also examples of elderly women who were financially secure. Their financial security was attained through pensions or savings. Margaret "was a working woman all my life - my pension is better. That helps an awful lot". In addition, she and her husband "put something away for our old age". As a result, Margaret was able to travel to Vancouver for yearly acupuncture treatments with "no problem because I have the money to do it". Lilac, an elderly woman who had spent several years looking after her husband who had been "really bad with Alzheimer's", attributed her financial security to her husband's disability pension from the army. Because of Lilac's financial security, she was able to own her own car and home, and travel "to the Caribbean, to eastern Canada, [and go on] a cruise [in] winter". By having financial security, these women were able to obtain health care at a distance, and enhance their quality of life by leaving the north during cold winter months. However, lack of adequate and secure finances can highlight and potentiate women's dependency and vulnerability, and affect their health day-to-day as well as long term.

Managing employment-related problems

Women identified two main employment-related problems: gender-based issues and stress. One gender-based issue related to lack of respect and sexual harassment. For example, Ruhi, a young woman who works as a manager at a restaurant, compared her experiences with those of a young male manager at the restaurant, "Everybody takes him seriously, they don't take me serious[ly]". Ruhi described situations where the male manager gave instructions and the employees obediently and unquestioningly followed them, whereas when Ruhi gave similar instructions, employees questioned, ignored, or unsatisfactorily followed her instructions. Ruhi attributed her experiences to the fact that she tries to protect employees from disciplinary actions and jobs that they find difficult. As a result, some employees take advantage of her kindness. In addition, Ruhi and other female staff experienced comments from customers about their dress or behavior, comments that constituted sexual harassment, "Whenever the guy comes [in] he harasses her...we have complaints about him...if the hockey teams come in, they are totally jerk people". Strategies used by women to address workplace harassment and respect issues included garnering the support of the general manager and becoming more assertive with employees and customers.

Another gender-based issue related to misperceptions about the work of women's centers and negative attitudes towards women and minority groups. Park, a woman who works at a woman's center, stated, "People have the perception that we're a bunch of men-hating lesbian women who are trying to break up the family". Park has tried to counter these attitudes with education in the community about the work of the center and about gender-based issues such as violence, and the need to respect diversity:

> We [at the women's center] take a stand...[We have the] Stopping the Violence program. It deals with all kinds of violence and sexual abuse, physical violence in relationships now as well...We have a rainbow committee which raises awareness and education with the public and in the schools...We also did a rainbow sticker campaign so that the homosexual community [and the multi cultural communities] would feel comfortable...being public, accept[ing] everybody - diversity, right...We are a member of the National Action Committee on the Status of Women... We need to look at more preventive measures so people have their own voice. Empowerment. Respect.

Another employment-related problem is stress encountered at work. Stresses were viewed as particularly salient because of women's strong commitment to their work, which often focused on people in crisis. Jocelyn, a social services worker, described some of the stresses in her work and her consequent need for balance:

> I'm very cognizant of the stress and strain that my work imposes...It's dealing constantly with people who are in...crisis. And, because I'm empathetic or intuitive or what have you, I'm always picking up these signals or my heart is reaching out or I'm trying to comfort people or trying to calm them down and it takes a toll. So I try to balance this with something else.

Achieving a balance between work and non-work activities was viewed as important to counteract work stresses. Some of the ways that women balanced their lives included taking advantage of the positive aspects of the north such as through outdoor physical activities, as Amelia explained, "I like the access to recreational [opportunities] right out my back door. I can go skating or cross country skiing". Other women balanced their lives by developing solitary personal interests and social connections. For example, Jocelyn enjoyed watching videos, her pets, reading books, "recharging" in her peaceful country home, and "borrowing" the children of friends as a surrogate aunt/grandmother figure.

Another strategy women used to manage work stress was part time employment. Part time work provides flexibility and a balance between the demands of work and home. Casey, a woman who lives on a ranch some distance from town, found that by relinquishing some of her work and volunteer commitments in town, "the stress levels are extremely low and it allows me the flexibility to travel...cutting down expenses for travel [to town] and for wardrobe." In addition, part time work exposes women to less vulnerability to weather, road, and unsafe driving conditions, as Casey noted, " I feel vulnerable on that highway...there's a couple of deaths every winter along the highway here and...if I have the opportunity not to work in town, I'm going to enjoy it."

In addition to engaging in part time paid work, women felt that work stresses could be decreased by equitable sharing of roles and ideas between women and men, both at home and at work. Park believed that "we need to accept that it's okay for men to be nurturing...there has to be a flexibility...I should be able to do the oil change [and] my husband should be able to do the dishes". Rhoda and Eileen both valued workplaces that included greater gender diversity. Greater exposure to gender diversity, and consequently to different ideas and behaviors, was viewed as providing greater role opportunities, expanded perspectives, and more intellectual stimulation, thereby decreasing vulnerability to "traditional" role expectations. Eileen summarized the benefits of working in a gender-diverse environment:

> You really need another gender's perspective in your life... [Men] talk more about politics...or we'll [he and I] discuss other things...I enjoy that intellectual challenge where people are not afraid of challenge...men are more willing to tussle and I just find women not very willing to do that because they want to maintain their nice friendly feelings.

Rhoda, who counsels at a women's shelter, thought that gender diversity was so important in her counseling work that "I wanted to work with men who batter - I wanted to balance my life because I work with women all the time and I felt that I was really getting over balanced with women and not working with men".

In summary, work and financial security are important for the health of northern women. Part time as well as full time work, volunteering, self-employment, and work as mothers, on farms, and in other venues are all important for northern women's health. Women have developed strategies to cope with barriers to employment and to financial security. Northern women have also devised ways to deal with employment-related problems such as harassment, lack of respect, and stress. Through resourcefulness, education, assertiveness, balancing work and non-work activities, and garnering equitable respect and behaviors from co-workers and family, northern women improve their work situations. Secure and satisfying work can contribute to the physical and mental health of northern women by decreasing isolation, and increasing women's voices, options, and influence within northern communities.

Resilient northern women make the best of the north by participating in northern activities, making decisions about health care services, seeking education and information, seeking and receiving social support, and working on financial and work issues. Resilient northern women also supplement the north, the topic of the next section.

Supplementing the North

In addition to becoming hardy and making the best of the north, northern women develop resilience by supplementing what the north offers. Supplementing the north may include adding to as well as changing what presently exists in the north. Strategies of supplementation included *being political* and *leaving the north, temporarily* or *permanently*.

Being Political

Many women in the study believed that being politically active was important for women's health in the north. As described in previous chapters, northern women have limited power and are silenced in northern communities. Northern women tried to counteract their limited power and silencing by being political. Being political was an attempt to change attitudes and behaviors in the north, and to bring attention and resources to northern communities. Political activism was often based on *valuing feminism*, and occurred as *personal advocacy* and *community advocacy*.

Valuing feminism

Valuing feminist ways of thinking and being that empower women was illustrated both explicitly and implicitly by women in this study: explicitly when women stated they valued feminism and feminist ideas, and implicitly when women described women-centered activities and perspectives without overtly identifying feminism as their underlying philosophy or mission. Some women did not speak explicitly about feminism or feminist acts. However, for some women, simply being who they are in northern communities can be considered to be a feminist act. Women who live lives that are outside traditional female roles may be seen to be "doing" feminism because they are living lives that do not fit with northern gender expectations of heterosexual marriage and motherhood.

Some women in the study, however, did speak quite passionately and openly about feminism and political action. These women tended to be older or of cultural minority backgrounds. For some, feminism is about freedom and rights, as Marie, a woman in her late 50s, stated, "men and women should be free to do whatever they are comfortable doing that isn't harming someone else...Everybody has the right to be the person that they are". For others, like Gert, an Aboriginal woman, feminism was linked to advocacy and political action:

> A feminist is someone who refuses to be a doormat. It means to love, honor, and respect the lives of women, and that there has been inequity, that there are a lot of aspects of women's lives that have been lost and robbed...It's important for me to do my part, globally, locally, or even to myself that advocates for our wellness, our rights, all of that.

This advocacy stance was also voiced by Lilac, a woman in her 70s, who felt that being assertive was important for women's advancement because, "if you don't push a little bit, a lot of things will just go under the carpet" and women's needs will be ignored, while "stepping on toes" and "pushing" helped to "open the road for the next people". Both Lilac and Signe, women in their 70s, felt that the women's movement and the media have helped over the years to advance awareness of women's issues and of the importance of more liberated lives for women.

Being a feminist in a northern community requires courage and the conviction of one's beliefs. For example, Marie, a woman who identifies herself as a feminist and who has undertaken blatantly feminist acts as a teacher in the north, noted that such behavior carries the risk of being ostracized by the community. Therefore, women may remain silent even if they subscribe to feminist beliefs:

> If you're blatant about it [feminism] and extremely open about your views, it's not really good because the women know that they can't really live it and take your side in a public debate...it's the acceptance factor...you find that a lot [of

> women] agree with you behind [your back]...on a one-to-one basis.

Thus, northern women may not openly subscribe to yet believe in feminism, or they may even vehemently and openly reject feminist beliefs and actions to avoid ostracism and to "fit in". As Marie intimated, silence about and rejection of feminist beliefs can be perceived as "health promoting" in that these actions avoid provocation and prevent ostracism. In small communities, such as those that exist in the north, where resources are limited and environments are challenging, being accepted and included is important for physical and psychosocial health.

Nevertheless, feminism is needed in the north because of the marginalization of women and their resultant vulnerability, which are brought about in part by gender expectations. The undervaluing of women, their decreased life chances and opportunities educationally and economically, as well as expectations and limitations about women's roles, all contribute to northern women's inequitable positions. These inequitable positions are best addressed through an understanding of feminist principles and actions because these principles and actions seek to empower women and change oppressive societal circumstances (Gough & Maslin-Prothero, 1994).

In spite of, or perhaps because of, negative societal attitudes towards feminism in many northern communities, northern women in this study engaged in personal advocacy and community advocacy.

Personal advocacy

On a personal level, women believed it was important for women to be assertive and able to advocate for themselves. Personal advocacy to decrease vulnerability related to inadequate health care was particularly emphasized. "Learn to advocate for yourself with your doctor. It's an important thing to remember", Leah advised. Casey agreed that "one needs to be self-reliant and that's not a bad thing...just being your own advocate will take you far". Several women discussed the effects of advocacy in helping women address physician attitudes. For example, Rosie felt she was finally able to obtain a diagnosis for her symptoms because of "nagging, [I said] to him, 'Look, this is not in my head, there's got to be a reason for it'", and because she was “quite capable of talking to my doctor as an equal”. Rosie also felt that being a nurse provided her with confidence and assertiveness to advocate for herself. Vicki noted that being assertive and advocating for herself has “made me question everything related to my health, which has not necessarily made me a popular person but, on the other hand, I’m still here talking about it. And I have discovered that you have to do that [be assertive and advocate]”. By being knowledgeable and assertive, northern women increased their chances of obtaining health care that promoted their health.

Community advocacy

Women engaged in community advocacy to decrease threats to psychosocial health and to decrease risks of inadequate health care. Community advocacy initiatives were mostly enacted by women who had adequate finances, time, commitment, confidence, social support, physical health, and other resources to sustain such initiatives. Community advocacy included advancing ideas and options for women who may not be able to advance these for themselves. For example, some women who were not abused participated in Take Back the Night walks on behalf of abused and intimidated women who felt that they could not participate in such a public way. Leah was involved with the advocacy program in the local women’s resource center which provided free legal services for taxation, tenancy, and other issues.

Other women used education and counseling strategies to change negative attitudes towards women. For example, Gert felt that in her work as a counselor “a big part of the work is changing that [redneck attitudes]..you know, educating...”. Gert also was involved in community theater as a way to present alternative ways of thinking to others. Rhoda instigated women-only support groups and enrolled in gender studies university courses. These activities helped her to help women clients to “start to take their power back and stand up for themselves more”. Through advanced education, Rhoda empowered herself and women clients because of her greater understanding of women and their place in society. Marie, a teacher, addressed sexist school materials by “changing pronouns and [using] female names when [storybook characters] are doing active things”. Marie also purposely purchased books for children that “showed women in a positive light", such as in non-traditional roles usually reserved for men, for example as firefighters. In these ways, northern women tried to foster changes in attitudes about gender expectations. As a result, their own health and that of other women in the community were enhanced.

Women were also involved in other diverse community advocacy activities that focused on women's issues. Examples of these activities included serving as a regional representative on the National Action Committee for the Status of women; subscribing to and writing for *Interior Woman*, a regional publication focused on northern women's interests and issues; encouraging and supporting women to use services such as the police; arranging for participation of low-income seniors in community events; and serving as a member of a local women's health committee that arranged women's education programs. These activities facilitated change and resulted in making a positive difference, purposes and consequences that were valued by several women in the study.

Advocating for the community also involved attempting to influence government policy makers. This activism involved participation in political parties, voting, and other activities that visibly brought local needs to town, regional, and provincial decision makers. It was hoped that these types of actions would highlight northern needs in such a way as to bring more resources to northern communities. For example, Barbara has been very involved in her community on a Tourism Task Force and on the community economic development committee. She had been a member of a community committee that met with the provincial premier to discuss health care concerns for her community, and she participated in a demonstration in which vehicles were stopped on the highway to inform people about the health concerns in her community. Barbara's activities illustrate the depth and scope of women's commitment to activism in northern communities. For some women, health care is of such a high priority that they are willing to risk breaking the law to gain public and legislative attention to improve health care in their communities.

Other women, too, were committed to influencing and creating health policy. For example, Vicki's concerns about health care in the north have led to her decision to seek the nomination for a political party in the next provincial election. She believed that "if women start to get out there and get involved in politics, I believe women can make a lot of difference". However, Vicki is aware of the commitment that political activism entails:

> I'm putting my whole life on the line. [I] have to have the time. It's almost a Joan of Arc mentality...if you were to look at some of those women pioneers, they've got a tenacity not to give up. You have to have a tremendous amount of tenacity and...be able to get up and speak...You've got to be able to curry team support...to make a difference...I think it's a pioneer mentality really.

Vicki's comments indicate the hardiness required to get involved politically. It is highly likely that northern women's hardiness serves them well in their political ambitions.

Northern women's political activism responses to their limited power and silencing were perhaps most evident in the women's expressions of the reasons for their participation in this research and their hopes for its utility. As indicated previously, women stated that they volunteered for the study in the hopes of making a difference, of gaining recognition and support for women's health, and of promoting women's health and women's lives in the north. Leah stated, "It's nice to share them [her perspectives] in a way that might help other people." Although Linda did not have many resources to devote to advocacy initiatives, by participating in this research, she hoped that "there's a chance that things could change because of this [research]...it's awesome if it can make a difference." Mary, an Aboriginal woman, stated:

> I feel it was important for me to say what other women have been telling me because I don't know how to make it go anywhere. And I know that research is important and can direct how the future is going to follow. So if I'm part of that [the research] then, hopefully, I'm helping to direct what's going to happen in the future.

By sharing their experiences and perspectives in this research, women illuminated their present resilience and their hopes for a better world for themselves and other women. Research opportunities such as those in this study are important in that they facilitate the inclusion of women with limited resources, such as time and finances, in activities that inform advocacy initiatives. The in-depth participation of the women in the study, who represent a diversity of experiences and backgrounds, and the commitment and enthusiasm of the many other women who volunteered for the study but who were not selected to participate illustrate northern women's deep commitment to political activism and the promotion of northern women's health.

Leaving Temporarily

Because of the limited options, physical and social isolation, and challenging climate in the north, leaving the north temporarily was a strategy that every woman in the study used to decrease exposure to vulnerabilities and to supplement her life. Traveling outside the north enhanced women's abilities to access social and physical environments that support their health. Women left the north for goods and services, respite, recreation, rest and relaxation, cultural pursuits, employment, health care, and to engage in activist activities.

Travel outside the north helped northern women obtain goods, services, and other resources that were either not available, were more limited in choice, or were more expensive in their home communities. For example, Marie stated that she would "go down to the coast just to stock up on things. Especially when my allergies were bad...I would stock up on rice flour and stuff because it was way too expensive here". Marie and other women in the study noted that they often bring back goods from southern centers for other northern residents, thereby increasing access and decreasing costs.

Women travel outside the north for holidays and other respites, especially in the winter months. Traveling to southern climates provides warmth and sunlight, which are lacking in the north. Some women obtain rest and relaxation and a change of scene by traveling to less distant places. For example, Marie, a teacher who works part time, often goes skiing or camping in the southern part of the province, and some women travel to Vancouver and Victoria for holidays. Women also leave the north to visit family and friends and to enhance recreational and cultural activities that are limited in the north. Leah, a northern woman who is a university student in the southern part of the province, takes trips to Vancouver and Victoria to visit friends and to access music, health care, and other resources. Indeed, many northern women would agree with Linda when she stated, " I feel like anytime you want to do anything fun, or new, or exciting, you have to go out of town to do it."

Employment sometimes requires women to travel outside the north for meetings, conferences, education, and other work-related events. Women will take these opportunities of being in a larger center to also enjoy cultural pursuits that are limited or not available in their communities. For example, Jocelyn noted that, when she goes to Vancouver on business, she also "go[es] to movie theaters and plays...and attend[s] the ballet". Thus work-related trips outside the north provide opportunities for relaxation, and help defray travel and entertainment costs.

Women also traveled outside the north to access health care services that were limited, nonexistent, or perceived as inadequate in northern communities. Indeed, Eileen would advise women who are planning to move north, "Keep your hairdresser and gynecologist in the Lower Mainland - keep your contacts in the city". Vicki stated that, "if you do need a doctor...go south. Don't go north. The doctors in the north from my experience make you feel like they're doing you a major favor by being here". Specialist services, particularly psychiatric and obstetric services, and second opinions for major health issues such as cancer and infertility were often obtained in large health centers outside northern BC. For example, Casey traveled to Vancouver because treatment for infertility does not exist in the north:

> [We were] planning to get down to Vancouver and the roads were bad, it's a 7 hour drive from here to Vancouver, longer if the roads are really bad...and I'm supposed to do this [hormone] injection at a certain hour. My GP and the nurse said, "Well, you could always go in at Hope and use the washroom"...it's like

shooting up like I was a junkie. But that's what you deal with here...

Because of the present shortage of all types of physicians in the north, some women traveled outside the north for family physician services as well. This was more common if women had moved to the north from elsewhere in the province because they could keep their family physician in their former community. By keeping their family physician, women could maintain some consistency of care; a high turnover of physicians in the north means that some women rarely see the same physician twice. Women who have family physicians outside the north with whom they are satisfied may endure the expense and time required to see them to obtain appropriate and consistent care.

Even when services exist in the north, some women traveled outside the north to obtain services more quickly or in a more acceptable manner. These women tended to have resources of time and finances so that they could cover travel costs and thus increase their access to appropriate and timely care. Vicki explained that she goes south for specialist care because "by the time you book the appointment [with a specialist in the north], a lot of them aren't there anymore." Referral centers in the larger centers in the south were also perceived as offering better quality of care. By traveling elsewhere, then, women felt they could obtain health care services that were more timely, respectful, and appropriate, and of a higher quality than what was available to them in northern communities.

Finally, women also traveled outside the north in their roles as advocates and activists. Again, these women tended to have adequate time and finances, as well as an interest in advocacy and activism. Women who were involved in political groups and activities traveled to meetings with political parties, the premier of the province, and other decision makers located in larger centers outside the north. For example, Leah, a university student and woman's activist, attended meetings in Vancouver as part of her involvement with the National Action Committee for the Status of Women (NAC). Leah stated that, "One of the reasons I'm sitting on NAC is so that I can inform women of the area [about] what women of the country are doing." Leah also stated that "the big mandate" of NAC is to "promote women's equality in your region", and she had several ideas about how she would do this, such as through the *Interior Woman* magazine and in Take Back the Night walks. Barbara, a woman with experience in community activism, accompanied other members of her community to meet with the premier of the province. "When we went there", she stated, "we were really hopeful that we would carry the message of the people that we deserved health care...we just wanted Victoria to hear." Thus, in these and other political actions, northern women are attempting to fortify the north by bringing resources such as knowledge and information from elsewhere back to the north. In addition, by informing power brokers, politicians, and others about northern needs, northern women are attempting to increase political awareness and garner support to enrich northern resources.

It must be noted that the ability of women to leave temporarily is influenced by several factors. Finances and time are needed to leave the north, and those women who are financially compromised or who do not have the time are less able to use the strategy of leaving temporarily. For example, Marie noted that "Flying out of here is phenomenally expensive", and Elizabeth stated that "Flying out of [some northern communities] is not an option for a lot of people" because of the cost. In addition, women who work full time have less time for travel outside the north, especially during the week. This can compromise their access to resources, such as health care, that are not available on the weekend in non-northern urban centers. Women who are physically ill also have difficulty traveling, as Signe noted, "I haven't flown since I've been in a wheel chair". In addition, the ability of women to access physicians outside of local communities is complicated by the challenges of selecting a physician from afar. Some women consulted with friends, family, and nurses about health care providers in other communities. However, if women do not have knowledgeable contacts and advisors, they must depend on their own - perhaps limited - resources. Thus, although leaving temporarily is an important strategy, because of lack of finances, time, and health issues, and because of lack of knowledgeable accessible contacts and supports, not all women can take advantage of this strategy, especially in a timely way.

In summary, temporary leave takings promoted women's health and resilience in several ways. Goods and services from southern locations increased the quality of life for northerners by increasing choices and decreasing the costs of living in the north. Vacations and other trips out of the north provided respite from the long cold dark winter months. When women returned, they were refreshed and better able to endure the remaining winter circumstances. In addition, women who attended educational and activist programs outside the north brought back knowledge and expertise that enriched their own lives, and that were shared with others. Obtaining health care services in southern locations increases quality of care, care that is more timely, and care that is more appropriate. In addition, for some women, obtaining care in southern locations makes possible their ability to obtain any care at all. Indeed, for some women, travel outside the north is vital to their physical and mental health, even their survival. ✓

Leaving Permanently

Leaving permanently is a strategy that represents an ultimate degree of supplementation of the north. During their time in the north, several women had used the other strategies of resilience noted in this study. However, at some point in their lives, such as at retirement, or to reach goals that were not achievable to their satisfaction in the north such as to obtain certain education or social and cultural connections, these strategies became insufficient, and some women selected the option of leaving the north permanently as a resilient way to maintain their health. Leaving permanently was for several women their escape valve, an option that they knew they had if and when coping with northern limitations became too onerous. Leaving the north permanently is a strategy of resilience because it requires courage and self-assertion to leave friends and family and a history of life in the north, however compromised, to begin another life elsewhere.

The climate, isolation, limited options, and attitudes in the north cause some women to leave the north permanently. Leaving permanently allows women to access the resources they need and want in ways that are acceptable to them and helps women avoid the limitations of the north. Women leave the north permanently to access education, employment, social support, recreation and cultural options, and health care. It must be noted that women in the study who considered leaving permanently had resources such as adequate finances and social support for the move from friends and family. In addition, these women perceived that there was something better that they were moving to, such as enhanced education and life opportunities, and closer contact with friends and family.

Women may leave the north to access education that does not exist in the north. Leah decided to move to Vancouver to study in a program that was not available in the north. Women may also choose education outside the north because of an undervaluing of educational programs offered in a northern setting, as Elizabeth explained:

> There's still this goofy attitude that if you don't come [graduate] from UBC then you're nobody...So, yeah, you graduated from UNBC [University of Northern British Columbia] but now you have to convince [others] that your education's as good. They assume it's not because you came from the north [from a northern university].

Elizabeth's comments reveal the existence of the undervaluing of the north. Northerners may detect this undervaluing, and, thus, choose education elsewhere.

Women may also leave the north for employment reasons. As discussed previously, the north has a limited range of employment opportunities for women. Thus, women may leave to find employment that fits with their abilities and interests. Barbara noted:

> The work base here is very small. Probably most of the women would be employed by the banks, the school, possibly the mine office and the sawmill...teachers...and nurses...It's probably a harder place [for women] to find work [here].

In addition, some women do not wish to travel long distances to work, especially in winter. Thus, women who would be required to commute to another community to work may seek employment in a less challenging environment where weather and distance are less problematic.

Women may also leave the north because they experience inadequate social support and a decreased sense of belonging or fitting in. People in the north may subscribe to values and behaviors that are different or not compatible with the values and behaviors of some women. For example, as a writer, Eileen found there were few supports and little interest in her work in her small northern community. Negative "redneck" attitudes towards her as a single mother, and as a woman made her feel undervalued, disrespected, and excluded. Eileen felt that people in her community "look at single moms as [being] poor, having made mistakes, not quite fitting in, as being peripheral". In addition, Eileen did not want her daughter to grow up in a "male dominated culture" where "girls think that the way to self-empowerment [is] to be like men" and to adopt male values. Consequently, Eileen was considering moving to a larger, more diverse community outside the north. Leah, too, was planning to move to Vancouver where "all my friends are."

In addition, women may leave the north to acquire enhanced recreational and cultural opportunities and a better quality of life. For example, Marie, a woman just entering retirement, is considering leaving the north to be nearer to family and to have opportunities that are not afforded her in her small community. Because of the couples orientation in her community and Marie's status as a single person, she has been discouraged from taking ballroom dancing lessons. These lessons are essential to Marie's plans to be a ballroom dancer on a cruise ship when she retires. By moving to a larger center, Marie will be able to satisfy both short term and long term goals. In addition, Marie is looking forward to leaving the "redneck" culture of the north, "the rough, crude part of it", and in leading "the quality of life that I want to lead".

Finally, women may leave the north permanently to access better health care, particularly psychiatric care. Although women may not leave the north solely because of lack of access to psychiatric and mental health services, not having access to these services contributes to this decision. Leah, a woman with obsessive compulsive disorder who is moving to Vancouver, explained:

> What I really look forward to [in Vancouver] is finding someone who has the same OCD [obsessive compulsive disorder] as me...Like there's an OCD support group in Vancouver. Whereas I don't know if you could even get one started here. People wouldn't come or there's just not the numbers. And the thing is, you can go to the support group in Vancouver and you're not going to run into them on the street like you would here.

Thus, living in a larger center outside the north enhances women's ability to access appropriate and confidential mental health services.

In summary, leaving the north permanently helps women avoid northern elements that they find unhealthy, and facilitates their access to goods, services, and other resources that support their health, on a permanent, more diversified, and higher quality basis. In other words, by leaving the north, women avoid the marginalization of living in the north that renders them vulnerable to health risks. Although leaving permanently increases women's health and quality of life, by their leaving, the north loses some of its brightest and most capable women.

This section has described strategies that northern women use in supplementing the north. Northern women supplement the north by being political, leaving temporarily, and leaving permanently. In these ways, northern women seek to add to their lives the goods, services, and other resources that are missing or inadequate in northern communities.

Summary

Developing resilience emerged as the core process northern women used to address their vulnerabilities to health risks. Northern women develop resilience by becoming hardy, making the best of the north, and supplementing the north. Women become hardy by taking a positive attitude, following spiritual beliefs, developing fortitude, and establishing self-reliance. Women make the best of the north by participating in northern activities, making decisions about health care services, seeking education and information, seeking and receiving social support, and working on financial and work issues. Women supplement the north by being political, leaving temporarily, and leaving permanently. These strategies of resilience reveal the creativity, courage, and resourcefulness of northern women to improve their own and their communities' well-being.

The need and ability of northern women to engage in the process of resilience are influenced by the northern context and by the marginalization women experience. The physical environment which includes long distances and challenging climate and terrain increases women's need to develop resilient strategies, while compromising their abilities to do so. The sociocultural environment and the isolation, limited options, limited power, and being silenced that northern women experience also influence women's health risks and the resilience they are able to develop. For example, women who are isolated and who have limited options may have greater risks, yet fewer resources to help them develop resilience to address risks. In addition, personal factors such as age, health and financial status, expectations, and previous experiences with hardship affect women's health needs and their abilities to develop resilience. Women who are older, who are unwell, and who have limited financial resources may have greater health needs, yet be less able to develop the resilience needed to attain and maintain their health. Conversely, women who have experienced hardship and who have realistic expectations of the north may be less vulnerable and better able to develop resilient strategies to maintain their health.

Developing resilience in the north has both positive and negative consequences. In the following chapter, I discuss these consequences of northern women's resilience.

CHAPTER VIII

FINDINGS: CONSEQUENCES OF NORTHERN WOMEN'S RESILIENCE

Women responded to their vulnerability to health risks by developing strategies of resilience. The strategies for developing resilience resulted in three main consequences for northern women's health and quality of life: thriving, surviving, and declining. Thriving represents growth and includes the development of physical, intellectual and psychological abilities that enhance health. Surviving implies stability and the ability to sustain physical, intellectual and psychological health. Declining is the deterioration of physical or emotional health or cognitive abilities and interests. Thriving was noted in this and other research (O'Leary & Ickovics, 1995) to be manifested in three domains: behavioral, cognitive, and emotional. This research further revealed that surviving and declining are also manifested in these three domains. Women experienced these consequences according to their ability to use strategies of resilience. Table 2 on the following page summarizes these consequences of resilience.

This study found that the more that resilience can decrease a northern woman's vulnerabilities to health risks, the better able she is to survive and thrive. Counter-intuitively, resilience can also lead to declining. For example, the short term and long term effects of resilience may differ. Although resilience can result in short term thriving or surviving, resilience can also result in long term declining because thriving or surviving in one domain may lead to declining in another domain. The case of Signe discussed in several places in this chapter is a vivid example of this phenomenon.

Northern women can experience thriving, surviving, and declining in various configurations. For example, a woman may thrive behaviorally, survive cognitively, and decline emotionally. In addition, the three domains are interrelated. For example, cognitive thriving may enhance thriving in behavioral and emotional domains. Moreover, the consequences of resilience may vary over time and in response to different situations. For example, a woman who is thriving behaviorally at one point in time, perhaps during the warm summer months, may decline behaviorally when winter arrives.

This chapter discusses consequences in terms of women's thriving, surviving, and declining, and how the contexts of northern women's lives and their personal, social, and other resources influenced their thriving, surviving, and declining in isolated northern settings. It must be noted that, due to the complexity of women's lives and experiences, thriving, surviving, and declining may also result from factors other than resilience factors, such as degenerative illnesses and aging. However, the chapter focuses on women's experiences and perceptions of consequences that are linked to the core process of developing resilience.

Table 2: Consequences of Resilience

	THRIVING (Growth)	**SURVIVING** (Stability)	**DECLINING** (Deterioration)
BEHAVIORAL	The development of enhanced physical abilities and behaviors that help women participate in activities and "fit in" with community.	The ability to achieve physical stability and endure, especially during adversity when physical health is compromised.	Physical and behavioral deterioration.
COGNITIVE	The ability to develop intellectual interests and abilities using local and distant resources.	The ability to sustain intellectual abilities and interests with local resources.	Deterioration of intellectual abilities and interests due to limited resources or limited access to resources.
EMOTIONAL	Enhanced psycho-logical coping so that greater self-confidence, independence, positive self-esteem, and happiness result.	The ability to psychologically cope with day-to-day stresses, to "get by".	Deterioration of the ability to fulfill expectations and achieve a happy life.

Thriving

When individuals are faced with challenge or adversity, they may respond by taking up the challenge or adversity, developing resilience to it, and thrive. Indeed, to be resilient means that an individual may not merely return to homeostasis but may move beyond the situation and grow or move forward (Kulig & Hanson, 1996), "go beyond the original level of...functioning, to grow vigorously, to flourish, ...to add value to life" (O'Leary & Ickovics, 1995, p. 128). Growth and moving beyond the original level of functioning are also manifestations of thriving (O'Leary & Ickovics). For northern women in harsh northern environments, resilient strategies led to growth and flourishing, and, thus, thriving. The thriving that the women in this study experienced can be described in three domains: behavioral, cognitive, and emotional. Although these domains are described separately, each domain affects the presence and degree of thriving in the other domains.

Behavioral Thriving

Behavioral thriving is the development of enhanced physical abilities and behaviors that helped women participate in northern activities and "fit in" with members of their communities. Women who behaviorally thrived were able not only to physically endure but also to enjoy and even look forward to demands in the physical environment. For example, Casey used the strategy of becoming hardy to successfully manage the family ranch while her husband was away. She learned how to effectively and safely lift bales, ride horses, and otherwise physically take care of herself and the ranch during all sorts of weather and times of extreme isolation, such as during winter storms. As physically demanding as this work was, Casey thoroughly enjoyed her life, "Having a physical life style works really well for me", and she looked forward to ranch work, in spite of its risks and challenges.

Women who were able to thrive physically were able to add value to their lives and to enhance their physical health even more. By making the best of the north, they were able to enjoy the often harsh northern environment and climate through activities such as camping, hiking, fishing, and other outdoor activities. Alice and Casey commented that their health benefitted from the outdoor physical activity that living and working on farms and ranches required. Casey, a ranch woman, noted that "It's a really positive step for my health living up here". Alice, a woman who enjoys life on the farm, noted, "I feel physically strong [because of the work]. Maybe I'm more hardy [because of it]".

Women who behaviorally thrived also felt a sense of inclusion in community and other activities. This feeling of inclusion was enhanced by women's ability to participate in activities that were condoned by the community, such as homemaking activities. Casey stated that since she and her husband have added a child to their family, Casey feels "more included" and part of her community where "certainly, there's a lot of reference to family". This inclusion promoted women's self-esteem and their support network, as they came into contact with women with similar values and behaviors. As a result, women who thrived behaviorally felt a sense of capability and belonging, which had a positive impact on their emotional thriving.

Women in the north who behaviorally thrive have significant personal, financial, and social resources available to them. Thus, these women are able to develop a range of resilient strategies, including those that require significant resources, to supplement the north. For example, Margaret and Vicki, women with substantial financial resources, could afford to leave the north temporarily to access more timely and appropriate health care in the south. Carmen and Lilac were able to enhance their physical health by taking holidays in winter in southern warm locales.

Cognitive Thriving

Cognitive thriving is the development of intellectual abilities and interests. The resilient strategies of making the best of the north by seeking education and information and supplementing the north by leaving temporarily were the most useful strategies for the development of cognitive thriving. Women who cognitively thrived were able to do so because they could access certain personal resources, such as finances to support travel, time and other opportunities to attend educational events, and the interest and educational background to appreciate the benefits that enriched education could bring.

Cognitively thriving women made the best of the north by engaging in strategies such as information gathering events over and above their usual personal, financial, and family demands. For example, Barbara learned the techniques of an alternative therapy on her own time and at her own expense. Other women in the study engaged in cognitive sharing activities for which they were not remunerated or even acknowledged, such as attending women and health care events in distant communities. Nevertheless, women often stated that they felt obligated and indeed were committed to sharing their cognitive abilities with others as a way to enhance options - and thus the value of living - in an isolated community with limited resources. As a nurse, Rosie was often consulted informally by people in her community. Rosie stated, "I end up doing a lot of reading and research for stuff [illnesses and conditions] I don't know that much about". However, Rosie realized that her abilities as a nurse were important in helping neighbors in her remote community access and understand health care, and she readily assisted them in their inquiries. Being able to contribute cognitively enhanced women's self-esteem and their ability to be independent and self-reliant, which impacted positively on their behavioral and emotional thriving and decreased their vulnerability.

Cognitively thriving women advanced women's interests by supplementing the north through political action and by valuing feminism. These women perceived that women's perspectives were important and should be heard, and they sought ways to advance their perspectives in public and other forums. For example, Rhoda believed that it was a good thing that "women are starting to take their power back and stand up for themselves". Women advanced women's perspectives through their roles as publishers, authors, and subscribers to a locally produced women's magazine, by participating in Take Back the Night walks, and by initiating and participating in women's education and counseling sessions. These activities contributed to women's self-esteem and to the sense that they were contributing to the enrichment of their communities. For example, Leah noted, "I guess that's one of the reasons I'm sitting on

NAC because...I can inform women of the area what women [in the rest of] the country are doing". In these ways, cognitively thriving women added value not only to their lives but also to the lives of others. These activities of cognitively thriving women enhanced their emotional health as well.

Emotional Thriving

Emotional thriving is the use of enhanced psychological coping that results in greater self-confidence, independence, positive self-esteem, and happiness. Emotionally thriving women had access to or were able to develop abilities to access needed resources. For some women, the ability to make the best of the north by enjoying the beauty and other characteristics of the north was enriching and contributed to their ability to emotionally flourish in challenging northern environments. For example, Gert stated, "There's a lot of access to real awesome beauty and that helps me stay healthy".

Women who thrived emotionally often had significant personal resources such as the ability to enjoy being alone for long periods and previous successful coping with adverse situations. For example, Lilac, an elderly woman who had lived in the north all of her life, noted that it was important to develop self-reliance, to "have things to keep you amused at home because there are times in the winter when you can't get out". Emotionally thriving women engaged in or learned how to engage in painting, crafts such as knitting, listening to or playing music, writing poetry and other fiction and nonfiction, and other solitary and creative activities that added significance and meaning to their lives. As a result, these women had resources to thrive emotionally in adverse circumstances, such as during the isolation imposed by winter weather.

The resilient strategy of seeking and receiving social support also assisted women to thrive emotionally. Social resources such as friends and family helped women add emotional value to their lives by decreasing isolation and enhancing support. Signe noted that "friends help me stay healthy. I'm never lonely". Marie stayed emotionally healthy because she sought to be "part of the lives of positive people".

Emotionally thriving women were often women who were content with - or came to accept - the limitations and challenges of life in the north. These women have successfully developed and used the strategy of becoming hardy, especially by taking a positive attitude and developing fortitude. For example, Barbara noted that when she was young, she wanted to leave the restrictions and "small town" perspectives of the north. Now, after several years of living in the north, Barbara stated, "I just enjoy living in a smaller area...I'm sure we'll be here forever". Perhaps this sense of happiness and contentment derived from the fact that emotionally thriving women seemed to have expectations that were more congruent with what the north could offer. For example, Robin was very content with the resources available in the north, whereas Eileen felt the absence not only of resources but also of like minded individuals. Robin had lived all her life in the north, whereas, although Eileen was born and grew up in the north, her adult life had been spent in large Canadian and American cities. Therefore, it may well be that northerners may be better able to thrive emotionally if they have lived most of their lives in the north, compared to northerners who experience opportunities and ways of being in non-northern settings. These experiences outside the north may set up expectations that are unrealistic in a northern environment. In addition, women who have lived much of their lives in a northern environment may have social resources such as friends and family who can help them thrive in challenging northern environments. Thus, these women may experience less stress and more support than women who are new to the north and who, therefore, have fewer social resources. Longevity in the north, then, may contribute to greater ability to emotionally thrive there.

Women's ability to thrive emotionally was influenced by and in turn influenced their abilities to thrive behaviorally and cognitively. Women who were able to physically manage in their environments and to obtain needed information were generally happier and more content than women who were not behaviorally or cognitively thriving. For example, Rosie, who has fibromyalgia and lives in a very remote area, loves the north and where she lives because she can "keep active physically and mentally" and still have access to cognitive pursuits such as reading and satellite television. The support of her husband and of her community, "It's like an extended family", facilitate Rosie's ability to be behaviorally and cognitively resilient and, thus, to thrive emotionally. Conversely, Fred, a woman with multiple sclerosis with few social supports, was restricted in her ability to drive and to remove snow from her driveway, necessitating her reliance on others for transportation and other assistance. This reliance created a sense of dependence and lowered self-esteem that resulted in decreased emotional thriving.

In summary, thriving for northern women must be considered within the context of all three domains of behavioral, cognitive, and emotional well-being. Thriving is affected by women's abilities to engage in strategies of resilience, which is in turn affected by personal factors, abilities, and experiences, and access to resources and supports.

Surviving

Although for some women in some situations resilience resulted in thriving and moving beyond a situation to grow and advance, for other women resilience resulted in the lesser state of surviving. Surviving indicates the ability to sustain physical, intellectual, and emotional health day-to-day. Surviving implies that the person achieves stability and balance and is able to go on with life (Wagnild & Young, 1990), but perhaps at an impaired or less than optimum level (O'Leary & Ickovics, 1995). In this study, women who were surviving were able to use strategies of resilience that helped them bounce back from difficult situations and survive, but not thrive. Personal factors such as financial and health status were often responsible for women not being able to use strategies of resilience that would have helped them thrive. Although surviving often occurred at an impaired or less than optimum level, it did allow women to achieve stability and balance and go on with life in the face of adversity. Women in this study exhibited resilience that resulted in surviving behaviorally, cognitively, and emotionally.

Behavioral Surviving

Behavioral surviving is the ability to achieve physical stability and endure, especially in situations where physical health and ability are compromised. Behavioral surviving is different from behavioral thriving in that behavioral surviving does not result in enhanced physical abilities and behaviors, when compared to what the woman experienced before the adverse or challenging situation occurred. Women survived behaviorally by persevering, by developing strengths and skills, and by being task oriented, yet flexible. Resources such as adequate finances and social supports influenced whether and to what degree women could behaviorally survive.

Women who were behaviorally surviving tended to use the resilient strategies of becoming hardy and making the best of the north. These strategies were favored because women who were behaviorally surviving often had limited resources, and these strategies allowed them to make the best use of the resources that were available to them locally or personally. For example, after a stroke, Margaret was able to re-develop the physical strengths and skills needed to live independently by taking a positive attitude, following her spiritual beliefs, persevering in developing fortitude, and using available home care services. Although Margaret was very committed to self-mastery and independence in her recovery, her ability to develop behaviors that helped her return to her previous life in her own home was greatly facilitated by the support of her daughter and by adequate financial resources to purchase some needed resources.

Behaviorally surviving women were less likely to use the strategy of supplementing the north due to lack of required resources such as finances and time. In addition, strategies that enhanced behavioral surviving in the short term sometimes affected long term health. For example, Signe, a senior woman with a debilitating bone condition, relied on her spiritual beliefs and local social supports because these resources were readily available to her and required little outlay of limited energy and finances. Although these strategies of resilience did decrease Signe's vulnerability to health risks day-to-day, they did not assist her in obtaining the care she needed to improve her health in the long term. In addition, some of these strategies compromised

Signe's emotional health by affecting her sense of independence and self-esteem.

Thus, although helpful in the short term to help women behaviorally survive, some strategies of resilience may serve to compromise women's long term health and their health in other domains. Nevertheless, for some women, such as those with limited financial resources and compromised health, these strategies may be the best they have available, given their needs and resources. Therefore, these women may remain vulnerable to health risks.

Cognitive Surviving

Cognitive surviving is the ability to sustain intellectual abilities and interests. Cognitive survival involves accessing resources that are locally or more immediately available, such as in a nearby community. Cognitive survival is different from cognitive thriving in that cognitive thriving includes going beyond immediate resources for information and intellectual needs. In addition, cognitive survival is focused on personal needs, rather than on the needs of others. Thus, women who were cognitively surviving were less involved in supplementing the north through community advocacy activities.

Cognitively surviving women used the strategy of becoming hardy. This included developing fortitude by learning from previous personal experiences - both successes and failures, and learning from others. These sources and ways of learning helped northern women believe in their abilities to survive and provided women with knowledge that they could use in other situations. For example, Elizabeth used the knowledge she gained from living in a very remote location when she moved to a less remote, but still new, northern environment. Her previous socialization strategies in a remote setting proved useful in helping her survive in her new environment. Jocelyn, too, felt comfortable moving to northern BC because of its similar culture to the northern Ontario community from which she came. Eileen relied on advice offered by her mother when Eileen returned home to the north. This advice helped Eileen tailor her outspoken communication patterns to the social relationships, lack of confidentiality, and other characteristics of communicating in small northern communities. As a result, she was better able to develop friendships and prevent misunderstanding and exclusion. Previous knowledge, then, provides women with confidence and enhanced capacity to make effective decisions and actions and cognitively survive. Thus, cognitive survival can positively impact upon behavioral and emotional surviving.

In order for northern women to cognitively survive, they must be able to access information. Thus, the strategy of seeking education and information was particularly important for these women. Several factors influenced women's ability to obtain information. Urban northern women were better able to access information than remote women due to the decreased negative influence of weather and distance. Women with financial resources could purchase goods, such as computers, and services, such as education programs, which enhanced their ability to obtain information and make health care decisions. Women who had social support in the north could benefit from the experience and knowledge that these people provided. Women with education and employment often had contacts or knew how and where to make contacts with resources that could help them develop cognitive survival skills. Women of the dominant English speaking Caucasian culture could access information resources more readily than immigrant women or women from minority cultures because such women were not faced with language barriers, cultural discrimination, and other barriers. Park noted, " When it comes to accessing services, they [immigrant women] may not even know these services exist. And language is a barrier for a lot of women". As a result, northern women's ability to cognitively survive depended upon their personal as well as their financial and social resources.

Emotional Surviving

Emotional surviving is the ability to psychologically cope with the day-to-day stress of life in the north. Emotional surviving differs from emotional thriving by degree; women who are emotionally surviving are able to "get by" in situations, rather than feeling a sense of positive optimal well-being.

Emotional surviving for women in this study resulted from various strategies of resilience. Following spiritual beliefs helped some women deal with isolation, lack of social support, lack of resources to obtain needed resources, and physical health issues. Taking a positive attitude was also an important strategy. Having a sense of humor, for example, helped women share and alleviate anxiety and created a more positive outlook on life. For example, Casey noted that the use of ranch humor - a dry type of humor - helps to share and relieve stress and also deflect problems and struggles common to northern ranchers. By sharing common struggles in humorous fashion, ranchers can decrease stress and create a sense of shared experience and community. A sense of humor can help people maintain their self-esteem, provide support by enhancing social connection, and sustain hope that things will improve (Balzer-Riley, 1996). By sharing a laugh and a common experience, humor may also open up communication between mutually troubled parties to enhance problem solving capabilities, thereby sustaining emotional survival. As Balzer-Riley stated, “What I can laugh at...I can cope with” (p. 187).

Seeking and receiving social support from friends, family, and professionals helped women emotionally survive day-to-day in challenging northern environments. For example, sharing activities and conversation helped some women develop emotional strength to deal with the long dark winter nights and short days that contribute to seasonal affective disorder, which is common in northern environments. Women often remarked on the importance of having women as social supports, because women share a common experience or bond that was often different from men. For example, women appreciated support from women who had also experienced and developed ways of coping with menopause, cancer, and other physical as well as mental health issues. Alice summarized what many women felt about social support by women, “ I like the interaction [with women], the similarities we have in common. We feel we are in the same boat. So, let’s meet and share”. Social support affirmed women’s experience as normal and valued, and helped them sustain competence, self-esteem, and emotional and physical health in high risk and adverse conditions.

In summary, surviving depends upon personal factors such as health and financial status as well as upon social and cultural values, expectations, and resources. If women can develop and use strategies of resilience, their survival is enhanced due to decreased vulnerabilities and enriched abilities and resources. In addition, it is evident that surviving in one domain influences the thriving, surviving, and declining that may occur in the other two domains.

Declining

Declining is the deterioration of physical or emotional health or cognitive abilities and interests. Declining may seem, at first glance, to be an unusual consequence of resilience, since the consequences of resilience are often claimed to be survival and growth (Richardson, Neiger, Jensen, & Kumpfer, 1990). Certainly, the more strategies of resilience a woman could use, the better able she was to resist the rate of decline. Nevertheless, in this study, some of the consequences for resilient women did include a state of decline behaviorally, cognitively, or emotionally. Women who thrive or survive in one or two of these domains can at the same time decline in the third domain. Thus, thriving or surviving in some areas of life may contribute to decline in other areas of life. Moreover, thriving and surviving in the short term may result in decline in the long term. Northern women's decline in any one domain or over the long term is affected by the nature and degree of their need, their ability to be resilient, and by northern physical and social environments. The following discussion illustrates how women in the north are at greater risk of declining than women who do not live in the north. In short, personal resources and circumstances combined with components of northern marginalization such as limited resources and isolation in the context of harsh northern physical environments create unique challenges for northern women that increase their vulnerability to adverse health consequences.

Behavioral Declining

Behavioral declining is defined as physical and behavioral deterioration. Behavioral declining implies that the ability to engage in health-promoting behaviors is diminished. Although women may be resilient in their ability to secure support from friends and family or acquire needed information, these resilient behaviors may inadvertently serve to prolong women's endurance of morbidity and potentiate their long term decline. Women who are particularly vulnerable may be able to develop strategies of resilience to survive day-to-day, but may not be able to develop strategies that would enable them to use resources or make decisions to improve their long term health. Their ability to "make do" is a short term trap. Their long term health may deteriorate, in spite of their ability to function day-to-day.

Although all women in the north have the potential to decline in physical health because of their vulnerabilities to health risks, women who are poor, elderly, and ill, and women with few social supports are particularly at risk. These women may not be able to engage in strategies of resilience that would decrease their health risks, such as strategies useful in supplementing the north. Although these women develop behaviors to cope in the best possible ways, these behaviors may contribute to deepening and prolonged deterioration and often compromise women in the short term and the long term. Because of their acute needs and limited resources, these women are often the least able of all women to endure further deterioration and compromise.

Another element that significantly affects behavioral declining for northern women is the availability of health care providers. The importance of professional health care providers in the north cannot be overestimated (Rennie, Baird-Crooks, Remus, & Engel, 2000). In fact, they are often more needed than in non-northern settings, and needed in ways that the "south" can barely understand. Limited access to most health care services and to female health care providers means that some women will not seek health care, as revealed in this and other studies (for example, Leipert, 1999), thus contributing to women's physical and behavioral decline as disease and illness progress and time to diagnosis and treatment is prolonged. Of necessity, women in the north must assume greater responsibility for their health compared to women elsewhere who have greater access to health care services. Women in the study who recovered, survived, and thrived frequently noted the importance of being able to access female nurses as a way to obtain respectful, effective, and woman-friendly support. For example, Margaret noted that home care nurses assisted her transition to life at home after her stroke. Signe noted, "I think there should be more home care nursing". Women in this study who were in a state of physical decline rarely received any or adequate nursing services.

Signe's experiences illustrate the behavioral declining that some northern women endure. Signe, a divorced low-income elderly woman, has made the decision to use morphine on a daily basis to deal with increasing pain, a consequence of the postponement of her surgery in the south. Signe must postpone this surgery until she can secure funds for travel. The morphine enables Signe to do the day-to-day things that sustain her life, such as shopping and visiting with friends, but she is not keen about taking it because of her perception of its long term effects, including dependency or addiction, and the social stigma attached to its use. Signe stated, "I don't like it [taking morphine], but until I've had the surgery, there's nothing I can do". Because of their increased infirmity, when treatment for women such as Signe does become available, it may need to be more invasive and less effective. Moreover, the recovery phase may be prolonged, which may require greater home support. Thus, some northern women, such as Signe, are compelled to develop resilient strategies that help them in the short term, but which nevertheless have long term consequences, such as prolonged morbidity which affects their illness and recovery.

Resilient strategies, however, may also have negative short term consequences or side effects. For example, Signe engaged in certain behaviors to deal with the pain and physical deterioration that result from prolonged exposure to a physical condition, "The morphine helps me sleep at night...[and] I walk with my cane or my crutches". Signe also used a wheel chair when going out. Although these "resilient" behaviors enhanced her capacity to cope in the short term, the morphine affected Signe's state of mind in that she felt like "I was with that Canadian lady [astronaut] - I was right out there with her", and the wheelchair interfered with Signe's ability to go out because she could not afford to pay for special taxi services. Thus, Signe's social and emotional health were affected by short term resilient behaviors. Nevertheless, Signe needed to adopt these behaviors due to her deteriorating physical condition, limited finances, and the limited options for treatment in the north.

Cognitive Declining

Cognitive declining is the deterioration of intellectual abilities and interests. The ability to use the strategy of resilience of seeking education and information was particularly important in preventing cognitive declining. However, even if women could engage in strategies to access education and information in the north, they could still cognitively decline if their intellectual and educational needs and interests were not met due to limited educational and informational options in the north. This was particularly true for women who had advanced education or who had experienced life outside the north. For example, Leah, a young northern woman who is a university student in the south, stated that "there is nothing to do" of a meaningful nature in her small community and that she spends much time alone working on the computer, since that was what was available to her intellectually. Leah felt that her isolated behavior was "pathetic", and she looked forward to leaving the north to return to university in the south. Eileen, a woman who had lived in a large American city for several years and who was now completing a Masters degree, noted the lack of like-minded individuals in her community who shared her interests in reading, writing, and other artistic pursuits, " I feel behind since I moved here...I miss knowing what books people are reading...I really miss the intellectual life...I don't feel that I'm being exposed to new ideas here".

Other factors in addition to education and life experience affect women's cognitive declining in the north. Women with limited finances cannot purchase resources such as computers or travel for educational purposes. Women in remote areas with limited access to electricity are compromised in their ability to use computers and telephones. Women from other cultures cannot readily find information in their languages or that reflect their cultural values and mores in small northern communities. Perhaps most compromised of all were the women who were physically or mentally unwell because these women had less personal strength and other resources to obtain information. Attitudes of health care providers, especially physicians, also hindered women's ability to be informed, as Rosie stated, "A lot of male doctors do tend to brush off women if they have a heavy case load in a small town". Because of a shortage of physicians in the north, all physicians have heavy case loads. Thus, most northern women are compromised in their ability to access information from physicians.

Cognitive declining affected women's emotional health in several ways. For women who valued learning, not being able to access information and education contributed to emotional declining by posing a threat to their self-esteem and their views of themselves as capable persons who were able to solve problems effectively. For example, Eileen stated that when she was denied access to a local parenting program, "I felt stigmatized for wanting to find more information about being a better parent". Women with advanced education, such as women with undergraduate and graduate education, noted that it could be difficult to establish friendships, since there were few other women with similar educational backgrounds, values, and interests. Cognitively declining also affected women's positive views of the future, since the education they needed for satisfying employment and relaxation was not available to them. Marie, a woman close to retirement, "can't get the courses I need to commence my chosen second career" and, thus, she did not see a future for herself in retirement in her small northern community.

Consequently, women who desired access to education or who had advanced education themselves often found that living in the north was an isolating experience. Such isolation was particularly problematic if these women did not have family, friends, or other social supports nearby to enhance their intellectual abilities and interests. Thus, the health and quality of life of women with cognitive interests is at risk of declining in northern communities, particularly if women do not have the resources to obtain education and information.

Emotional Declining

Emotional declining is the deterioration of the ability to fulfill expectations and achieve a happy life. Emotional declining was evident in women's expressed unhappiness or lack of fulfillment in northern environments. Women who were emotionally declining or at risk of emotional decline were women who did not have the necessary resources to cope with the north, or women who valued a life that could not be provided in the north. In addition, due to employment or social commitments, some women in the study were trapped, "stuck", and immobilized in the north, which resulted in emotional declining, or the threat of emotional decline.

Northern women with less than adequate resources are at risk of emotional decline. Limited financial resources may increase women's vulnerabilities to health threats by affecting their abilities to develop or make the best use of such strategies as making the best of the north and leaving the north temporarily or permanently. For example, Linda and her family had limited financial resources due to her husband's insecure income at the mine. The need to travel elsewhere for affordable children's clothing, foodstuffs, and recreation created additional costs that the family could ill afford. As a consequence, Linda stated:

> We're not real keen on [our community]. We don't find there is a lot to do here...Ever since we moved here, we have found more hardship. It seems harder for us to do things here because we can't afford to. That, I think, is the biggest issue.

Emotional declining was also affected by women's personal values. Women who valued a life that was different from what was possible in the north were at risk of emotional declining. For example, Marie, a retired teacher; Leah, a young university student; and Eileen, a writer who had lived in large cities and who sought a culturally diverse, intellectually stimulating, and egalitarian lifestyle, all found the north limiting in attitude and opportunity. These women experienced decreased educational and recreational options in the north, and they also had difficulty finding friends with similar interests, as Marie commented, "It's difficult to find people that are interested in more than the day-to-day cooking and scrubbing and going to work and coming home". In short, although the emotional aspects of these women's lives were compromised by limited social resources in the north, the emotional declining these women experienced was also affected by the values they held. As a result, these women were considering leaving the north permanently to enhance their emotional as well as their cognitive and behavioral health. The decision to leave the north permanently, although resilient personally, contributes to the transient nature of northern communities which obviously adds to the isolation of northern women. Supportive friends often move away.

When considering the concept of declining, it was noted that interrelationships and influences between and among domains also existed; northern women may be declining in one domain while also surviving and thriving in other domains. Interrelationships and influences between and among domains were in part affected by women's access to personal and social resources. Signe's case provides a vivid example of these interrelationships and influences. Although Signe was declining behaviorally as her physical disability deepened, her emotional state included a high level of contentment and peace, apparently a state of thriving. Signe's positive outlook on life, her religious faith, many supportive friends, and her previous experiences in adverse situations contributed to this emotional thriving. Nevertheless, some women, in spite of their resources and the influences of other domains, remain at particular risk of declining. Women most at risk of declining are those who experience more health risks or more severe health risks, those who must rely to a significant degree on their own resources, and those who have more limited resources.

The holistic nature of women's perceptions of health underline the interrelationships and influences that exist among the behavioral, cognitive, and emotional health domains. Many women in the study noted interrelationships among these domains. Signe stated, "As long as you keep your mind busy, you're going to be healthy". Barbara noted, "Health means state of mind because whatever will happen to your exterior body, it's where you're at in your mental body that can make you better".

Alice summarized the beliefs of many women in the study when she said, "There is a combination between the physical health, the spiritual health, and psychological health. The balance should be there".

In summary, this study revealed that northern women decline behaviorally, cognitively, and emotionally. The nature and degree of declining that northern women experience depends upon several factors. Resources such as friends, family, and employment help to prevent or offset adversities and vulnerabilities. In addition, personal factors such as financial and health status, educational background, life experience, and women's values and expectations also affect declining. It was also found that interrelationships and influences exist among the domains; for example, declining in one domain influences the other two domains and vice versa. Women's holistic perceptions of health highlight the importance of and relationships among behavioral, cognitive, and emotional domains.

Although the discussion in this chapter has focused on consequences resulting from resilience, it is also evident that these consequences 'feed back' and affect the process of developing resilience. For example, a woman who is thriving may be better able to use resilient strategies and, indeed, develop additional strategies. A woman who is declining, on the other hand, may be compromised in her ability to develop and use resilient strategies, thereby increasing her vulnerabilities to health risks and increasing her need for resilient strategies. Thus, the consequences discussed in this chapter reflect not only effects of resilience, but also impacts upon resilience.

Summary

This chapter discussed the consequences of resilience - thriving, surviving, and declining - and their manifestations in the behavioral, cognitive, and emotional domains. From this discussion several important features are revealed.

First, each of the three consequences of resilience are exemplified in each of the three domains. The degree to which women thrived, survived, or declined was dependent upon their abilities to develop and use strategies of resilience. In addition, the strategies of resilience that emerged in this study - becoming hardy, making the best of the north, and supplementing the north - were evident in all three consequences. However, some strategies were more prevalent in some consequences. For example, women who thrived made more use of the strategy of supplementing the north than women who survived or declined. Although strategies of resilience could not completely decrease all vulnerabilities, they could make some vulnerabilities easier to bear. Conversely, some strategies of resilience could also contribute to increased vulnerability and women's declining.

The degree to which women were able to develop and use strategies of resilience depended upon several factors. Personal factors such as health and financial status, personal values, previous experiences, and geographical location affected if and how women could develop and use resilient strategies. Seasonal and climatic challenges in the north also affected if, when, and how certain strategies of resilience could be used. Women who had fewer health problems, who could access more resources, who valued northern life, and who had experience in the north tended to survive and thrive to a greater degree than women who had health problems, who could not access resources, who valued life that could be experienced outside the north, and who had limited experience in northern settings. These latter women remained vulnerable to health risks and were more at risk of declining.

The findings of this study also revealed interrelationships and influences between and among the three domains. Thus, for example, a woman may be thriving in one domain at the same time as she is surviving or declining in other domains. In addition, this study found that the consequences that result from the process of developing resilience may also influence the ability of northern women to develop and use resilient strategies.

The consequences of resilience discussed in this chapter suggest implications for women's health and quality of life in northern environments. These implications are addressed in the next and final chapter.

CHAPTER IX
DISCUSSION

This chapter includes a discussion of the study findings in light of current literature. Limitations of the study and implications for women's health research, health care practice and health-related policy, and health practitioner education are also discussed. The chapter begins with a brief summary of the study findings.

Summary and Conclusions

This study examined how women stay healthy in northern BC. Data from interviews with twenty-five women revealed that vulnerability to health risks is the core problem that women must address to stay healthy in northern BC. This vulnerability results from conditions of marginalization arising from the northern context. To address these vulnerabilities, northern women engage in a multifaceted process of developing resilience. The ability to develop resilience is affected by the degree of marginalization a woman experiences, as well as by personal factors. Consequences of thriving, surviving, and declining result from women's use of strategies of resilience.

The marginalization, vulnerability, and resilience women experience occur in and are affected by the northern context. More specifically, the northern context includes a historical location, and physical, sociocultural and political environments that have positive and negative effects on northern women's health. This northern context leads to marginalization in the forms of isolation, limited options, limited power, and being silenced. Marginalization occurs for northern women primarily as a result of their gender and their geographical location. As a result of marginalization, northern women experience vulnerability in terms of physical health and safety risks, psychosocial health risks, and risks of inadequate health care. To address these vulnerabilities, northern women develop resilience by becoming hardy, making the best of the north, and supplementing the north. Consequences of resilience for northern women include thriving, surviving, and declining in behavioral, cognitive, and emotional domains. These consequences are a result of resilience but also in turn affect the ability of women to develop resilience.

The findings of this study suggest that personal factors affect northern women's abilities to prevent vulnerable situations from developing into negative outcomes and their abilities to develop resilient approaches. Age, health status, education, financial status, cultural background, lifestyle preferences, and experience in the north are some of the personal factors that affect women's needs and their abilities to stay healthy. For example, women with limited finances are less able to use the strategy of resilience of leaving the north for goods and services to address the marginalization that leads to health vulnerabilities in the north.

Although women with limited resources throughout Canada may need to rely on what is available locally (Amaratunga, 2000a; Rennie, Baird-Crooks, Remus, & Engel, 2000; Young, 1997), the depth and scope of factors in the north such as extensive distances and isolation, prolonged severe climates, and fewer health and human service resources make northern women's needs more acute, their solution options more limited, and their plight more problematic. Moreover, a 'pile-up' or accumulation of limited personal and social resources increases vulnerabilities. Again, although women in more southern rural and other marginalized settings in Canada also experience effects from the pile-up of limited resources (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1996; Young), some women in the north are particularly vulnerable due to the accumulation of the demands placed on them by northern physical and sociocultural environments, personal circumstances, and the very limited resources that exist in northern communities. For example, a physically unhealthy woman who lives in an isolated northern setting and who has limited finances or social supports is much more vulnerable to health risks and has decreased ability to develop resilience compared to a similar woman who lives in a southern setting where there are more resources that are more accessible.

It can be concluded that all women in the north, because of the marginalization engendered by geography and gender, are vulnerable to health risks and, therefore, need to be resilient to maintain their health. Geography, climate, political forces that act to exclude northern women from resources, decisions, and power, in addition to attitudes that 'keep women in their place' in invisible and undervalued settings and roles undermine all northern women. In the context of these factors, all northern women are challenged to develop resilience to reach their full potential for health and quality of life.

Discussion of the Findings and Recent Literature

In this discussion, I consider the study findings in relation to rural and northern literature and in light of theoretical literature relating to the major concepts of the theory. It should be noted that literature about northern women is limited, and literature that does address women in the north tends to be general and speculative about northern women's health. The main findings that I consider in this section are the centrality of resilience to northern women's health, the need for enrichment of societal and institutional structures in the north, and the importance of feminist qualitative methods in research related to northern women's health.

The Centrality of Resilience to Northern Women's Health

This study revealed that developing resilience is central to northern women's health due to the vulnerability that northern women experience. In this section, I situate these study findings within the larger body of literature that addresses women's health and resilience within the northern context, and within the literature that provides theoretical perspectives of the concept of resilience.

Women's Health and Resilience Within the Northern Context

This study confirms and extends what others have found in other northern environments in Canada regarding northern women's health and the resilience they need to develop in response to vulnerabilities. In this study, women revealed that they were vulnerable to health risks and that their health was compromised by certain aspects of life in the north, such as isolation, limited options, limited power, being silenced, and northern environments. Women in this study used a variety of strategies of resilience to address their vulnerability including becoming hardy, making the best of the north, and supplementing the north.

The women in this study identified vulnerabilities of physical health and safety risks, psychosocial health risks, and risks of inadequate health care. In the sparse literature that focuses on northern women, health vulnerabilities to which northern women are exposed are addressed minimally and often only tangentially. For example, although Southcott's (1993) analysis of healthcare inequalities in northwestern Ontario revealed that the situation of women in isolated resource-based single-industry towns resulted in detrimental health conditions for these women, no elaboration about these conditions is provided. However, health risks for women in BC, including northern women, have been documented in the 1996 Report on the Health of British Columbians (Provincial Health Officer, 1996). In this Report, it is evident that northerners in general and northern women in particular are at risk for negative health outcomes due to air pollution, discrimination, and inadequate and inappropriate access to health care resources. These risks make women more vulnerable to chronic diseases, high levels of violence and feelings of insecurity, substance misuse, mental health issues, and reproductive health issues. Although northern women's health is recognized in the Report as being particularly at risk, these risks are minimally addressed and are usually described statistically and epidemiologically; the voices and perspectives of northern women regarding the risks in their lives are not included. Thus, detailed accounts of health risks as articulated by the women in this study are particularly significant. In addition, this study identifies and elaborates upon factors that affect northern women's vulnerabilities to health threats.

The women in this study spoke about marginalization and vulnerability for particular groups of northern women. For example, Aboriginal and lesbian women were identified as being particularly at risk for discrimination and prejudice. Similarly, Browne and Fiske (2001) have noted that northern Aboriginal women's encounters with health care services are often shaped by racism and discrimination, which marginalizes these women and places them in "situations of vulnerability" (p. 138). Anderson et al. (2000) in their research about barriers to health care for lesbians in northern BC noted that discriminatory attitudes towards lesbian women in the north affect lesbian women's vulnerability and their commitment to and ability to find adequate health care.

The perspectives of women in this study who are disabled, elderly, young, or from the Indo-Canadian culture provide a beginning understanding about the marginalization, vulnerability, and resilience of these northern women. Literature about the marginalization, vulnerability, and resilience of northern women who are disabled, elderly, young, or from ethnic minority groups other than Aboriginal is virtually nonexistent. Thus, the perspectives of the women in this study about the vulnerabilities and resilience of these groups of northern women provide important new information.

In this study, women's responses to vulnerability included developing resilient strategies to manage immediate challenges, as well as strategies to change present conditions. Similarly, Luxton (1980) in her study of women's work in northern Manitoba found that in response to feelings of boredom, loneliness, and depression, women used social support for immediate relief and political action, personally and in collaboration with others, to achieve long term change. The women in my study confirmed additional ways of dealing with health challenges that have been documented by others. For example, Gill (1984) in her study of Canadian resource-based communities in northern Manitoba noted that women sometimes dealt with challenges through alcohol and other drug abuse, pregnancy, marital breakdown, and migration out of the community, strategies also noted by women in my study. Other ways of coping that Gill noted such as suicide and obesity were not mentioned by women in my study and would be fruitful areas for future research with northern women. The women in my study agreed with Gill's recommendation that "greater efforts need to be made towards understanding the needs and attitudes of women" (p. 71) in northern communities. Findings from my study and the limited information available in the literature also indicate that further knowledge is needed about the strengths and resilience of northern women.

Beyond the limited research regarding Canadian women in northern environments, literature regarding women's vulnerabilities in other geographically isolated settings in Canada, such as rural settings, reveals similarities to the findings of this study. Like the women in this study, women in rural Atlantic Canada experience poverty, geographical isolation, insider-outsider status, and social and political exclusion (Amaratunga, 2000a, 2000b, 2000c; Stewart et al., 1996). Congruent with my study, Saskatchewan rural women identified poverty, violence against women, and mental health as some of their priority issues (The Rural Women's Health Partnership, 1999). The women in my study noted undervaluing of the north and of women and lack of resources as factors that influence vulnerability. Similarly, Saskatchewan women believed that attitudes of politicians and health care providers regarding rural areas, lack of resources, and lack of a rural women's voice in policy formulations were largely responsible for their health issues. The finding in this study that inadequate health care is a major concern to northern women is reflected in a recent national study about quality of life in Canada (Canadian Policy Research Networks, 2001). This national study revealed that rural people rated the health care system as an important factor in their quality of life but that health care access and the quality of the health care system are problematic.

Some of the strategies of resilience identified by the women in this study are reflected in research involving rural women. Research by Young (1997) into Alberta farm women's perceptions of health and work reveals that, similar to this study, women in her study valued a positive mental attitude and taking responsibility for one's health. Similar to northern women, rural women are creative and self-reliant, use self-care and alternative healing practices to cope with lack of resources, and try to exert control over risks by being assertive, problem-solving, and becoming hardy (Bushy, 1998; Young). Furthermore, both northern and rural women are often not only responsible for their own health, but they may also facilitate the health and health care of their families, friends, and communities (Bigbee, 1990; Dunkin, 1998).

Although some of the issues faced by southern rural women and strategies they use to maintain health are similar to those of northern women, these issues and strategies often differ in degree. For example, climate, distance to resources, physical isolation, and lack of resources in the north can be more problematic. Consequently, northern women must often make greater efforts if they are to develop resilience and maintain their health in the face of sometimes almost overwhelming challenges.

This study revealed that women are not powerless to advance their health in challenging environments. By developing and using the strategies of resilience of becoming hardy, making the best of the north, and supplementing the north, women in this study were able to respond to vulnerabilities and health risks. This study's findings about women's resilience expand our understanding of women's compromised positions and experiences in the north, and reveal that some women are able to develop resilience and thrive in northern settings. In addition, these strategies of resilience highlight and testify to often overlooked and undervalued attributes of northern women such as their strength, courage, and resourcefulness. Thus, findings in this study about how and why northern women develop resilience provide important new information about women and health that is only minimally addressed in the literature.

Theoretical Perspectives of Resilience

The process of resilience developed by northern women as articulated in this study is examined here within the context of theoretical discussions of resilience presented in the literature. Because vulnerability and marginalization emerged as key components influencing the development of resilience, these concepts will also be examined.

Several disciplines have been engaged in research and discussion on aspects of resilience, vulnerability, and marginalization including psychologists (Kobasa, 1979; Werner, 1985), sociologists (Delaney, Brownlee, & Zapf, 1996; Luxton, 1980), health educators (Richardson, Neiger, Jensen, & Kumpfer, 1990), nurses (Flaskerud & Winslow, 1998; Hall, Stevens, & Meleis, 1994; Polk, 1997; Sebastian, 2000), and physicians, particularly psychiatrists (Rutter, 1987). Because of the medical model approach to health and its influence on health policy and funding, much of the research historically has focused on the study of risk, vulnerability, and illness, rather than on resilience, protective factors, adaptive strengths, and health (Richardson, Neiger, Jensen, & Kumpfer; Wright, 1998). This study, by revealing the centrality of resilience and its relationship to vulnerability and factors that promote as well as hinder resilience, serves to advance understanding about the concept of resilience.

Resilience

The women in this study developed the strategies of resilience of becoming hardy, making the best of the north, and supplementing the north. These findings contribute to a growing body of knowledge regarding the concept of resilience. Study of the concept of resilience emerged from the field of psychopathology and child development. Resilience has historically been studied most extensively with children living in adverse conditions (Felsman & Vaillant, 1987; Werner, 1989) to explain how some individuals maintain healthy lifestyles in spite of adversities and stressors. More recently, resilience has been studied with additional groups such as adults with cancer (Jacelon, 1997), physically disabled individuals (Fine, 1991), adolescent mothers, and survivors of sexual victimization (Wright, 1998). The concept of resiliency has also been applied to families (McCubbin & McCubbin, 1993) and, more recently, to communities (Kulig, 2000; Stewart et al., 1996).

The theory of developing resilience emerging from this study suggests that developing resilience is an interactive and changing process that develops in response to environmental and personal conditions that influence health. This aspect of resilience is congruent with views expressed in the literature. Richardson, Neiger, Jensen, and Kumpfer (1990) view resiliency as an interactive and ongoing process between the individual and the environment, rather than as an inherent characteristic or end product. Similarly, Hall, Stevens, and Meleis (1994) noted that, "Resilience incorporates the capacities gained from person-environment interactions that foster survival" (p. 33).

Resilient strategies in this study included immediate, reactive responses as well as more proactive action for longer term effects. The women's strategies of resilience incorporated both behavioral and cognitive strategies to deal with immediate challenges posed by marginalization and vulnerability (such as becoming hardy, and seeking education and support), and they also developed strategies (such as political activism) to address longer-term needs and issues related to the root causes of their vulnerability. Kulig and colleagues (Brown & Kulig; 1996; Kulig & Hanson, 1996) also emphasize this 'two-fold' nature of resilience. These authors note that, in the first sense, individuals act in such a way as to "recover from what they define as negative physical or social events" and, in a second sense, individuals act to "transform their physical and social environments to mitigate against such events in the future" (Brown & Kulig, p. 30). These perspectives reflect a view of resilience as an immediate reactive response as well as a more proactive action for longer-term effects.

The women in this study exhibited many characteristics of resilience such as becoming hardy by taking a positive attitude, following spiritual beliefs, developing fortitude, and establishing self-reliance. Many of these characteristics are reflected in related ways in the literature. Wright (1998) described key characteristics of resilient individuals as including an active approach to solving life's problems, an ability to perceive even negative experiences constructively, an ability to gain people's positive attention and support, and a strong reliance on faith or spirituality to maintain a positive view of a meaningful life. Polk (1997) noted that the qualities of being independent, being able to actively problem solve, and the belief that self-knowledge is valuable were all important characteristics of resilient people. Wagnild and Young (1990) revealed that characteristics of successfully adjusted older women include a hardiness that encompasses equanimity (a balanced perspective of one's life), self-reliance, perseverance, meaningfulness (the realization that life has purpose), and existential aloneness (aloneness as a wellspring for creativity, comfort, and self-acceptance).

The women in this study also engaged in explicitly behavioral strategies of resilience such as seeking education and information, seeking social support, working on financial and work issues, and being political. These strategies helped women achieve important purposes and consequences that are also reflected as important in the literature such as reducing risk impact and preventing the occurrence of additional stressors; fostering personal coping skills; promoting self-esteem, self-efficacy, and hopefulness; and opening up opportunities in education, work, and social relationships (Wright, 1998). Development of women's personal resources and competence and increasing women's social support and political power have been identified as contributing to the development of resiliency and positive change despite marginalized and vulnerable life conditions (O'Leary & Ickovics, 1995; Stewart et al., 1996; Wall, 1993; Wright).

Women in this study consistently noted the importance of individual, family, and support factors in their development of resilient responses to vulnerability. For example, personal problem-solving abilities and supportive spouses and friends were deemed important in the development of the women's resilience. These factors have also been noted in the literature as important in assisting individuals to counter vulnerability and risk (Brown & Kulig, 1996; Mangham, Reid, McGrath, & Stewart, 1995). Three broad categories of protective factors have been postulated to contribute to resilience in individuals: factors within the individual such as problem-solving skills and social competence, family factors such as having a supportive spouse, and support factors such as having networks beyond the family (Mangham, Reid, McGrath, & Stewart). Many of these protective factors are also reflected in this study as important for the development of resilience.

This study provided new insights into the consequences of resilience. The study identified consequences of thriving, surviving, and declining in behavioral, cognitive, and emotional domains, and revealed that women could be thriving, surviving, or even declining in these three domains simultaneously. In addition, it was revealed that these consequences may vary over time and across situations. These findings about the consequences of resilience and, in particular, the findings about the negative consequence of declining, are referred to only minimally in the literature. Fraser, Richman and Galinsky (1999) have suggested that resilience does not necessarily imply invulnerability, and Wright (1998) indicated that individuals with the capacity for resilience can also experience a loss of functioning and deterioration in health, especially in highly stressful circumstances. Thus, the findings of this study confirm and extend our understanding of how resilience can result in both positive and negative health outcomes.

Vulnerability

Because women in this study developed resilience in response to the central problem of vulnerability, it is important to consider the concept of vulnerability here. The concept of vulnerability that emerged in this study refers to exposure to health risks, particularly physical health and safety risks, psychosocial risks, and risks of inadequate health care.

In this study, vulnerability was influenced by both environmental and personal factors. Environmental factors of the northern context and the conditions of marginalization influenced the nature and degree of vulnerability women experienced. Personal factors such as age, health status, financial status and cultural background also influenced the degree of women's vulnerability. This study revealed that interrelationships exist between environmental and personal factors to influence the degree of vulnerability women experienced. These conceptualizations and expressions of vulnerability are congruent with conceptualizations of vulnerability presented in the literature.

The importance of environmental and personal factors and of their interrelationships that produce vulnerability are supported in the literature. Hall, Stevens, and Meleis emphasized the significance of environment in their definition of vulnerability as "the condition of being exposed to or unprotected from health-damaging environments" (Hall, Stevens, & Meleis, 1994, p. 33). More specifically, Hall (1999), Hall, Stevens and Meleis, and Stevens, Hall, and Meleis (1992) noted that environmental factors such as ecological, structural, and interpersonal circumstances that result in discrimination, environmental dangers, unmet subsistence needs, and restricted access to health care threaten physiological or psychosocial well-being. Flaskerud and Winslow (1998) have suggested that personal factors such as physical health status, genetic disposition, and personal perceptions influence vulnerability. Interrelationships between personal and environmental phenomena in the construction of vulnerability have also been noted in the literature (Health Canada, 1996; Lancaster, 1999; Sebastian, 1999).

The nature and 'causes' of vulnerability revealed in this study point out that vulnerability is primarily determined by factors over which women usually have little control. Similarly, Lancaster (1999) has noted that, in most instances, vulnerability is not a personal deficiency; rather vulnerability represents interaction effects of many factors over which the individual may have little or no control. In this study, marginalization and women's location in the historical, physical, sociocultural and political environments of the north are factors that contribute greatly to northern women's vulnerability. These factors are difficult to influence and manage, especially by individuals who have little power. Thus, although northern women develop resilience, they may remain vulnerable to health risks because of their inability to address factors that are out of their control.

The current study, which sought individuals' perspectives about their lives and which also examined the communities and societies in which northern women live, identified how environmental factors (e.g. historical, physical, sociocultural, political) influence vulnerability directly as well as through their influence on marginalization and personal circumstances. Flaskerud and Winslow (1998) contend that the concept of vulnerable populations requires "a community health perspective...that views communities as responsible for the collective well-being and health of their citizens" (p. 69). This study may provide a clearer understanding of how various aspects of communities contribute to vulnerability, particularly within a northern setting. This knowledge can assist communities, as well as health care practitioners, policy makers, and women themselves, to identify more clearly the causes and conditions underlying their health risks.

Marginalization

Marginalization relates to experiencing inequitable access to resources that are felt to be necessary to achieve and maintain health. More specifically, marginalization as articulated in this study was characterized by isolation, limited options of goods, services, and education, limited power, and being silenced. Similar conceptualizations of marginalization are reflected in the literature. Jenson's (2000) review of the concept of marginalization suggests that marginalization occurs "when people are systematically excluded from meaningful participation in economic, social, political, cultural, and other forms of human activity in their communities and thus are denied the opportunity to fulfil themselves as human beings" (p. 1). Hall, Stevens, and Meleis (1994) view marginalization as a sociopolitical process characterized by exclusion from power and resources. Thus, marginalization is similarly characterized in this study and in the literature as a lack of capacity to meaningfully participate or gain full respect in society.

A strength of this study is that it articulates and clarifies factors that contribute to northern women's marginalization. Within the context of this study, both geography and gender were key bases of marginalization, reflecting structured inequality. Geographical and gender-based factors such as geographical location, gender expectations, and discrimination influenced women's marginalization. As described in previous chapters, the north is marginalized by the rest of the province and sometimes by northerners themselves. Marginalization by the rest of the province is due to the undervaluing of the north by the south, and is evidenced in exploitation and under-resourcing of the north. Marginalization of the north by northerners is due to an intolerance for diversity and a privileging of men's priorities, and is evidenced by an undervaluing of women's perspectives and needs. In addition to these factors, this study revealed that personal factors such as physical and mental health status, age, education, finances, cultural background, and past experiences in marginalized settings also influenced the degree to which women experienced marginalization. More specifically, the literature suggests that those most at risk of being marginalized in

Canada include racially marked groups, youth, the long-term unemployed, single mothers, people with disabilities, and Aboriginal people (Jenson, 2000). All of these groups exist within the northern context. However, because the north is itself also marginalized, these populations may be particularly vulnerable to health risks.

These various factors that affected northern women's marginalization are reflected in a generic way in the literature. Hall, Stevens, and Meleis (1994) noted that one's identity, associations, experiences, and environments can all form the basis of an individual's or a group's marginalization. Various attitudes and behaviors such as discrimination, scapegoating, stigmatizing, and segregation may also serve to marginalize women (Faugier & Sargeant, 1997; Hall, Stevens, & Meleis). These factors of marginalization expressed in the literature are confirmed, clarified, and extended by the articulation in this study of the various geographical, gender-based, and personal factors that affected northern women's marginalization.

While there is considerable research focusing on marginalization related to race and ethnicity, gender, and socioeconomic exclusion, less attention has been directed to marginalization resulting from geographical location. Nevertheless, some geographers and political scientists have discussed marginalization in terms of the northern terrain and distance, and sociopolitical and economic factors in the north such as voter representation and single resource communities (Coates & Morrison, 1992; McCann & Gunn, 1998; Weller, 1993). These views from the literature about the nature of geographical, economic, and political marginalization, its causes and effects, reflect similar findings in this study. Nevertheless, the existing literature does not focus on how marginalization in a northern geographical location affects women's health. Therefore, this study extends knowledge about northern marginalization by clarifying how marginalization experienced by northern women influences their vulnerability and their abilities to develop resilience.

The Need for Enrichment of Societal and Institutional Structures in the North

This study found that northern women in BC experience societal and institutional restrictions to their health. The women in this study had limited employment opportunities, they felt that the north was not valued and was marginalized by the south, and they had difficulty accessing appropriate health care and other resources and services to maintain and enhance their health. These findings support the view that societal and institutional structures often negatively affect the health of women (Smith, 1987).

These study findings are similarly reflected in other writings about the north and northern women. Gill (1984) and Heald (1991) also noted that male-dominated employment in other northern settings in Canada does not include or only marginally includes women. Similar to my study, Lucas (1971) and Gill also revealed in their writings about northern resource-based communities that negative attitudes towards women and a frontier mentality that tends to favor traditional gender roles limit the ability of northern women to reach their full potential and to access resources to promote their health in ways that women deem important. The persistence of colonial perspectives of the north that keep northerners under resourced and with limited political power has been noted in my study and by others (Coates & Morrison, 1992; Weller, 1993). Moreover, findings in this study confirm what others have noted about the Canadian health care system; the Canadian health care system as a whole favors illness care and physician-centered practice over health promotion practices and an enhanced scope of practice for nurses and other health care providers (Rachlis & Kushner, 1989).

This study revealed many resilient strategies that northern women develop to address societal and institutional inadequacies and barriers. However, in spite of their abilities to develop effective strategies of resilience, northern women cannot and must not be expected to address or correct societal and institutional structural inadequacies on their own. Some of these inadequacies can only be altered through changes in government policy and intervention. The collective political will in communities, regionally, provincially, nationally, and globally, must exist to change societies and institutions to more equitably address women's health issues (Doyal, 1995, 2000; Gill, 1984; Ramp, 1999).

Women in this study agreed that both men and women must be part of the societal and institutional change that is required to effectively address northern women's health issues. They advised that men and women work together to achieve more egalitarian attitudes and behaviors in the north. Similarly, some authors have noted that support for women's health in the north will require change by men, women, institutions, and society as a whole, especially where gender issues and societal and institutional attitudes and behaviors are more entrenched (Gill, 1984; Heald, 1991; Nadeau, 1982). Findings from this study suggest that enhancing northern women's health must necessarily include health institutions as well as education, employment, recreation, and other institutions that shape values about and behaviors toward women and that provide women with resources to achieve their potential.

Although this study focused on women's health, an important tangential finding is that investment in women's health and quality of life can prove pivotal to the advancement of the health and quality of life of all northerners, including northern families and communities. Northern women who are healthy, happy, and fulfilled are better able to support themselves, their families, and their communities. This finding supports the findings of other studies about northern women. Gill (1984) and Luxton (1980) both have noted that women act as a "stabilizing force" (Gill, p. 61) in creating and sustaining satisfaction or dissatisfaction on the part of a male employee's family in northern communities. Thus, women have a large impact on the quality of life of northern families, as well as on the economic stability of small northern communities. In addition, women have played a major role in social welfare development in Canada's north (Luxton; O'Gorman & Delaney, 1996). Northern women raise children, take part in community life, and keep the community together. Northern women are tenacious and able to improvise and, with their compassion, mutuality, respect, and commitment, they have made a difference to the lives of all northern people (Luxton;

O'Gorman & Delaney). Consequently, for the advancement of northern women and their families and communities, northern women's health and quality of life must become a priority - locally, regionally, provincially, and nationally.

Women in the study hoped that this research would prompt governments to direct resources towards supporting and advancing women's health within northern environments. However, they noted that this would require the south, where the seat of government is located, to value the north, a situation that the women were not confident would happen. The provincial government is beginning to focus on the particular needs of women as evidenced by recent documents published by the BC Ministry of Health and Ministry Responsible for Seniors (2000) and the Provincial Health Officer (1996). Recently, the BC Ministry of Health and Ministry Responsible for Seniors recommended six health goals for BC women. Although these goals are important for northern women in BC, they focus on issues and solutions that are often irrelevant or not feasible in northern environments. In addition, the document tends to overlook the strengths, needs, and abilities of northern women. For example, the document suggests that to increase safety for women, public transportation should be available at later hours. For most northern women, public transportation does not exist at any hour because there are no buses in most northern towns. Although the document recommends increased access to prenatal care and to cervical and breast cancer screening programs, no specific recommendations are provided as to how access could be enhanced in isolated, under-resourced northern settings. Clearly, governments must expand their understanding of women's health issues and solutions to include information that is relevant and useful for northern women.

Northern women's health also receives minimal attention at the federal government level. A poignant example of this inattention occurred during the course of this study, when a national rural and northern health summit was held in Prince George, BC. Women's issues were not part of the summit agenda, even after women requested that their issues be included (Appendix M). In addition, the registration fee to attend the summit was prohibitively high, excluding many women from attending. In response to their exclusion, women picketed the proceedings as participants arrived to register for the summit, and a group of northern women developed their own one day summit to run concurrently in the same city as the national summit. From their own women's health summit, participants prepared a list of recommendations (Appendix M) that they subsequently presented for inclusion in the national summit findings.

These actions on the part of northern women and the political actions identified and engaged in by women in this study indicate that, to achieve structural change to enhance northern women's health, women must become politically involved in local, provincial, and national initiatives. Others have also suggested that the enrichment of societal and institutional structures in the north will be best achieved by involving northerners themselves, including northern women, in the identification and development of these structures (Graham, Brownlee, & Dimond, 1996; Luxton, 1980). Northerners, by virtue of their experience, can provide important information about what is needed and feasible within the northern context.

The Importance of Feminist Qualitative Methods in Research Related to Northern Women's Health

This feminist study is important because it acknowledges and includes northern women as legitimate knowers about women's health, a situation that rarely occurs for northern women. Women in this study appreciated being acknowledged, respected, and taken seriously. Much of this appreciation arose from the women's usual experiences of having limited power and being silenced, of not being listened to, ridiculed, or dismissed by physicians and other northern men. Women from minority cultures particularly valued their inclusion, as they felt that their voices are seldom consulted or heard.

Women valued the respect conveyed by visiting them in environments where they felt comfortable, and in listening - really listening - to what they had to say. For some women, this was the first time they felt sufficiently empowered to honestly express their experiences, knowledge, and desires regarding their health. In short, the feminist approach taken in this study suggests that, when women are consulted and included in research in respectful and meaningful ways, they are able to share knowledge that is invaluable to the advancement of women's health. Thus, feminist research of a qualitative nature is of key importance in research related to northern women's health.

One of the most significant issues facing nursing scholars and practitioners is related to feminist research, theory, and epistemology (Keddy, 1993). The epistemological question of 'who can be a knower' has been described as the fundamental motivational force behind feminist research (Olesen, 2000). Knowing in science has traditionally had an androcentric bias because research questions, data, and analyses have been based on the experiences of men (Acker, Barry, & Esseveld, 1983; Gilligan, 1982). In addition, much of what is known about women's health has originated in urban environments, and in the discipline of medicine, a profession with a distinctly male bias (Bella, 1996). Feminist research seeks to give voice and legitimacy to women's experiences and knowledge (Campbell & Bunting, 1991), wherever that experience and knowledge may be located.

This study provided diverse perspectives from women who were elderly, young, and middle-aged; disabled and able-bodied; poor, middle-class and wealthy; Caucasian and from minority cultures; and from various locations including remote, rural, and urban. Thus, this feminist research assisted in providing 'multivocal' (Hall, 1999) knowledge about women's health from women with diverse backgrounds and perspectives. Such diverse information assists in understanding how determinants of health such as income, age, ethnicity, and geography affect northern women's health.

A particular strength of this research is that it advances the articulation and importance of context in the lives of northern women. Because there is so little extant research about northern women's lives and contexts, this study provides important new data. Walters, Lenton, and Mckeary (1995) emphasize that the effects of the contexts in which women live must be considered when women's health is being addressed. Thus, the finding of this study that the northern context affects women's physical, mental, social, and intellectual health contributes important new information regarding northern women's contexts, the effects of these contexts on women's health, and women's efforts to maintain their health within these contexts.

Feminist research, by including and valuing women, can be health promoting and empowering in its own right (Hajdukowski-Ahmed, Denton, O'Connor, & Zeytinoglu, 1999). Eileen, one of the women in this study, noted, "[being part of the research] got my thinking processes going about myself and the larger culture and that was all emotionally and intellectually very satisfying". Jocelyn, another study participant, stated:

> I realized having talked to you that I did a whole lot of complaining but I wasn't offering solutions...like preventive measures...but I can see that I'm conscious about it [northern women's health issues] and I will do something should the opportunity arise.

As these comments indicate, by bringing to voice, this feminist research provided opportunities for women to be visible and audible, to identify and reflect on their issues and act on them, to have control over their well-being and that of their communities, and to promote their health.

Study Limitations

All research must acknowledge a variety of limitations due to time, skill, money, and creativity. This study was also susceptible to limitations related to personal bias, nature of the sample, nature of the data, and analytical sensitivity (Glaser, 1978).

Personal bias can affect a grounded theory study from the identification of the problem to the final stages of the study. Some of my personal biases include my strong attachment to feminism, as a cognitive and evaluative position. I also have a firm commitment to preventive health care, and I strongly believe that prevention and health promotion resources are systematically under resourced. In addition, my personal and professional experiences and my reactions to rural, northern, and isolated settings could be other sources of personal bias. As a public health nurse, I experienced having to provide services with woefully inadequate resources, and I provided services to women who were oppressed, and who suffered physical and emotional violence. Personally, I have dealt with discrimination against nursing as a female profession, and I have experienced gender bias on numerous occasions. These personal and professional commitments and experiences could have influenced this study.

I tried to protect against personal bias by using strategies recommended by Glaser (1978). I "enter[ed] the research setting with as few predetermined ideas as possible...especially a priori hypotheses" (Glaser, p.3), and I delayed hypotheses generation until data collection was well established. In addition, I attended to potential personal bias issues by eliciting the involvement of study participants and my dissertation committee members in the analysis of the data. I also bracketed thoughts and perceptions in a journal throughout the duration of the study as a way to identify and prevent possible distortion by personal bias. During the interviews, I used an open-ended questioning technique, and I was conscious of minimizing any suggestion as to how I would answer the question. Reviews of interview tapes and transcripts also helped me to identify possible personal bias such as inappropriate or prejudiced questions and to prevent this in subsequent interviews. In these ways, I attempted to maintain a stance and interpretation that would as accurately as possible reflect the perspectives of study participants.

The *nature of the sample* may also pose limitations in that the 25 women in the study could not represent the perspectives of all northern women. The size and nature of the sample no doubt affected the amount and type of information that became part of the study data. However, the relatively large sample size (Morse, 1994) and the diversity of the sample membership helped to ensure that resultant data were rich and varied, thereby forming a solid basis for a substantive theory (Glaser, 1978). Bias could have been introduced in the selection of the 25 women for the sample from the over 100 women who volunteered to be part of the study. However, my purpose in sample selection in this grounded theory study was to select individuals who could contribute to the evolving theory (Creswell, 1998) and provide comparisons, contrasts, and enrichment for emerging categories and properties of categories (Glaser). Nevertheless, there were gaps or 'thin' areas in the sample. For example, there were only two women in their twenties and one woman in her eighties who volunteered for the study; future research might seek to recruit more women in these age groups. In addition, only one woman from a very remote area volunteered to participate. Involvement of more women from remote areas would help elaborate on the life and health circumstances of extremely isolated northern women.

The *nature of the data* may also give rise to some limitations. It is possible that participants may not have represented their experiences accurately or completely due to limits in recall or because they wished to present socially desirable responses (Field & Morse, 1995). I addressed these potential limitations by establishing face-to-face relationships that fostered trust and respect. Establishing rapport that was respectful helped create an environment that was comfortable, which was particularly important in this study because of its focus on sensitive and personal women's health issues (Cotterill, 1992; Devault, 1990). Several participants remarked that they felt comfortable in sharing sensitive information because they found my interest in the study and my regard for them to be genuine and respectful. In addition, by interviewing participants several times, I believe I was able to foster rapport and more comprehensive and honest recall.

There may also be limitations in the *analytical sensitivity* of the researcher. In a grounded theory study, the researcher must be able to analyze data in a theoretically sensitive way in order to generate a meaningful theory (Glaser, 1978). Theoretical sensitivity refers to "the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't" (Strauss & Corbin, 1990, p. 42). Since sensitivity is a matter of degree, one can always be more sensitive.

Theoretical sensitivity can be enhanced by professional and personal experience and in-depth knowledge in the area of study (Glaser, 1992). I used my knowledge and experience as a community health nurse and as a resident in rural and northern geographically isolated settings to sensitize myself to relevant concepts and their relationships. Therefore, I was able to use relevant prompts and communication techniques to elicit meaningful data in interviews. In addition, I used my experience and knowledge of life in rural and northern settings to increase my sensitivity to contextual data in my travels for research purposes throughout the north. For example, because I had lived and worked in small communities, I was better able to assess the significance of resources and relationships in small communities. Such assessments facilitated my understanding, analysis, and articulation of important concepts, relationships, and theory. Moreover, to foster my theoretical sensitivity, I reviewed the literature widely in several disciplines and areas including nursing, women's health, public health, women's studies, social work, psychology, geography, and medicine. I also consulted with my dissertation committee members, thereby enhancing my theoretical sensitivity and the development of a meaningful theory.

In spite of the ways I sought to enhance my theoretical sensitivity and address other study limitations, the infinite nature of theoretical sensitivity and the complexity of issues inherent in the field of women's health will always challenge a single researcher. Nevertheless, this study has contributed to enriched and new understandings of northern women's health vulnerabilities and of how women in the north develop strategies of resilience in response to vulnerabilities to maintain their health. The study has also provided new insights into the consequences of developing resilient strategies.

Implications

Several implications arise from the findings of this study. These implications will be discussed in relation to women's health research, health care practice and health-related policy, and health practitioner education.

Women's Health Research

Limited research exists about women's health in northern geographically isolated settings. This study provides a beginning data base regarding women's health in these settings. Thus, the theory developed in this study should be further elaborated and tested to enhance its utility for diverse groups of women in northern and other geographically isolated settings. In this study, there were some groups of women who were not well represented. Therefore, additional research is needed regarding the health issues and resilience of women in very remote settings, women in their reproductive years, disabled women, the elderly, and women from various cultures. Additional research could also provide insight about the utility of the theory for understanding and addressing women's health in diverse isolated settings. For example, further testing of the theory in both rural and other northern settings could help articulate some of the distinctiveness and effects of rural and northern settings as they relate to women's health.

The study findings point to gaps in knowledge regarding key health issues in the north. For example, more information is needed regarding mental health issues of northern women. As well more research that compares health status, health care, and health issues of northern women and southern women in BC is also needed to clarify understanding of contextual factors that affect women's health. Research in these areas would provide information that would lead to more relevant delivery of health care services to women in northern settings.

This study focused on the development of individual resilience. Given that many of the factors that lead to vulnerability at the individual level are rooted in community and societal structures, it would be useful to explore resilience at the community level. Research that would enhance understanding of resilience at the community level would be useful for northern women and northern communities, particularly for communities that are at risk such as those that are rural or remote and those that are dependent upon one industry (Kulig & Hanson, 1996).

An interesting finding of this study was that developing resilience can lead to declining in health and well-being. This phenomenon has not been investigated in any depth in previous research. Therefore, further research that investigates the dynamics of how resilience leads to declining would strengthen understanding of negative as well as positive consequences of resilience. In addition, such research would assist northern women and health care providers to facilitate and support those aspects of resilience that lead to positive health outcomes.

Research methods that directly involve northern women should continue to be used in subsequent research. Participatory action research using focus groups with northern women could extend the findings of this study. Asking northern women to reflect collectively on and add to the study findings would deepen and extend understanding about northern women's situations. In addition, these methods would increase northern women's awareness of shared and unique experiences, facilitate acknowledgment of expertise, and help to empower women to engage in actions to transform institutional structures that inhibit women's health (Hajdukowski-Ahmed, Denton, O'Connor, & Zeytinoglu, 1999; Kemmis & McTaggart, 2000; Madriz, 2000; Reutter, Neufeld, & Harrison, 2000; Writing Group of the 1996 AAN Expert Panel on Women's Health [Writing Group], 1997). In addition, more feminist research that focuses on women's health must be undertaken in the north. Further feminist research could elaborate upon northern women's life circumstances, their needs, and their abilities, provide northern women with important opportunities to promote their health and their liberation, and help counter northern women's oppression.

Research that addresses the effects of social, economic, and political structures that create ill health for women is required so that healthy public policy can be advocated, based on sound research data. Research with a focus on policy analysis would assist in identifying the impact of existing policies on northern women's health. The development in 1996 of five Centres of Excellence on Women's Health, funded by Health Canada, has enhanced funding for women's health research that focuses on broad issues, such as those related to sociopolitical and contextual factors that affect women's health and health care. In addition, the launch of the Canadian Institutes of Health Research Institute of Gender and Health in 2001 has broadened research priorities to include themes of access and equity for marginalized groups, gender and health across the lifespan, and gender and the environment (Stewart, Kushner, & Spitzer, 2001). The creation of these groups bodes well for the advancement of women's health research throughout Canada. For women in the north, research funding bodies such as these must recognize the importance of qualitative research about women's health in the north and its costly and time-consuming nature, and they must provide enhanced funding that appropriately supports such research.

Health Care Practice and Health-Related Policy

This study has identified specific vulnerabilities to health risks and conditions that influence these vulnerabilities. One of the most significant health risks for women in northern BC is the risk of inadequate health care. There is a need to address the factors that lead to inadequate health care by increasing the availability of and access to health services for women in the north. Strategies to address this need must attend not only to the quantity but also to the quality of health care service delivery. Several recommendations to enhance health care delivery in the north are offered here.

Services must be expanded in northern communities to include more diverse health care services and enriched health care practices and programs. For example, services by midwives and nurse practitioners would significantly enhance health care for northern women. There is also a need to increase the number of health care providers including more community health nurses, mental health counselors, family physicians, and medical specialists such as psychiatrists, gynecologists, and surgeons. Enriched alternative health care providers and services are also needed in the north. The introduction of community health centers that focus on health promotion and illness prevention services and the empowerment of women (Attridge, Budgen, Hilton, McDavid, Molzahn, & Purkis, 1997) would also be very useful. This study revealed that it is imperative that access to services be achieved in relevant ways in the north. For example, women in the study found that traveling vans that bring services to rural and remote women are beneficial.

To strengthen health care practice, increased efforts must be made to recruit and retain health care professionals in the north. To facilitate recruitment and retention and the provision of respectful and appropriate care, northern employers must ensure that health care professionals are comfortable with the professional and personal aspects of living and working in small northern communities (Stokes, 1996). For example, northern health practitioners must be able to work in environments that are culturally diverse, where lack of anonymity prevails, where isolation and distance are a fact of life, and where they may be regarded as outsiders (Canitz, 1990; Dunkin, 1998).

The study finding that gender attitudes contribute to northern women's vulnerabilities has important implications for the delivery of health care services to northern women. Northern women are rarely included in or consulted about health care, and they experience disrespect and exclusion, especially from physicians. Thus, it is recommended that sensitivity to women's issues be enhanced in health care practice settings. One way to do this is to adopt a feminist framework in practice (Woods, 1995; Writing Group, 1997). A feminist framework takes into account the context of women's lives, including sociopolitical factors that influence health and health care (Writing Group). When a feminist framework is used, a relationship is fostered between women clients and health care practitioners that promotes opportunities for women, fosters women's willingness to take responsibility for and make decisions about their health, and promotes women's effective participation with health care providers (Woods). This framework supports a range of services that encompasses women's total person, not just their reproductive functions. Such a framework, if adopted by health care providers in the north, would facilitate respectful and inclusive care for women, and would support northern women's desires and abilities to achieve self-efficacy and resilience. The achievement of this recommendation will be a long term endeavor, however, because of the medical model that is entrenched in the Canadian health care system, and the patriarchal attitudes that pervade perspectives and practices of health care and other human services providers (Rachlis & Kushner, 1994; Tudiver & Hall, 1996).

This study revealed that interventions at the policy level are particularly important since it is at this level where many of the problems originate and can best be addressed. Women in the study identified several physical and social environmental influences on their health such as environmental degradation, limited cultural and recreational amenities, and undervaluing of women through attitudes and inequitable opportunities. Several policy recommendations can be made to address these concerns.

The provincial government must strengthen and enforce adequate policies that govern air and other pollution by pulp mills and other northern-based industries. Provincial and local governments must work together to provide funds for a variety of high quality cultural and recreational resources that support women's interests in the north. Government policies must ensure good road maintenance and electrical and telephone services to remote areas. Policies and practices that address gender inequities in the north must incorporate a commitment to affirmative action policies, particularly in male-dominated resource-based industries, to ensure that women are hired into positions and paid and promoted according to their abilities and equitably to men. It is noted, however, that the recent severe downturn in northern resource-based economies with subsequent loss of employment and population and the depth and scope of recent provincial cutbacks to services and programs will make problematic the achievement of these recommendations.

The need for policies and practices that address root causes (such as gender discrimination and other sociopolitical factors) of northern women's vulnerabilities has implications for the roles of nurses and other health care practitioners. These roles must include advocating for healthy public policy and the utilization of community development and coalition building approaches. Advocacy activities that are for and with women and that use effective strategies (Labonte, 1993) are especially important in northern settings to increase resources and support and to give power and recognition to the situations of northern women. Community development and coalition building strategies that assist people to support each other and build on each other's strengths (Labonte, 1992; Raeburn & Rootman, 1998) are particularly important in small northern communities that have limited resources. By focusing on community and social ties, improvements can be made in the social status, social capital, and human capital of women (Aday, 2001). Using advocacy, community development, and coalition building initiatives, awareness of women's issues can be raised and possible solutions suggested and implemented.

The unexpected finding that resilience may lead to declining suggests that practitioners need to look beyond immediate evidence of client resilience to determine its short term and long term implications. Questions such as the following should be considered when working with vulnerable clients: What resilient strategies is the client using? What are the short term and long term effects of the client's resilience? These questions may reveal inappropriate or ineffective strategies or strategies that require supplementation to enhance their effectiveness. Nurses and others can act to enhance strategies that foster thriving and surviving and can work with clients to address strategies that contribute to declining in health and well-being.

From a broader theoretical perspective that will enhance nursing practice, this study has elaborated the concept of environment. Nursing theory and practice are guided by the metaparadigm concepts of person, health, environment, and nursing (Chinn & Kramer, 1999). However, within the discipline of nursing, the concept of environment has received little research attention (Kleffel, 1991; Stevens, 1989). With an enhanced understanding of the concept of environment, nurses are better able to identify causes and influences of health issues and to "assist [clients] in more fully understanding their realities and their positions within them" (Moccia, 1988, p. 13). In this study the environment was revealed as multidimensional with historical, physical, sociocultural, and political elements. The environment played a key role in determining women's vulnerabilities to health risks as well as their abilities to address their vulnerabilities. Attention to the environment is a key concept of the socioenvironmental approach to health (Labonte, 1993), an important approach for nursing practice (Reutter, Neufeld, & Harrison, 2000; RNABC, 1994). Thus, this study, along with other socioenvironmentally oriented research, can assist nurses to effectively and comprehensively assess northern environments, and to plan and implement relevant health promotion initiatives at the individual, community, and policy levels.

Health Practitioner Education

Appropriate education for students in the health care professions is critically important if these future professionals are to assist women to enhance their health in challenging northern environments. Baird-Crooks and Graham (cited in Rennie, Baird-Crooks, Remus, & Engel, 2000) found that nursing students were amazed at the variety of knowledge and skills required to work in rural areas and often desired professional experience in rural areas once they graduated. As an educator of students in northern settings, I have found similar student perspectives.

Curricula for nursing education programs must include extensive and diverse knowledge to facilitate northern practice that advances women's health. Findings from this research point to areas that should be included in nursing curricula, such as factors in the northern environment that threaten women's health, women's vulnerabilities to health threats as well as their efforts to address health issues, and factors that influence women's abilities to maintain their health. Clearly, prospective northern nurses must have a knowledge base that integrates public health, primary health care, nursing, and sociology (Bushy, 2000; Delaney, Brownlee, & Zapf, 1996; Foster, 2000). Preparation for rural and northern nursing practice should also include knowledge about rural and northern health risks and resources, rural and northern cultures, systems of influence in rural and northern settings, partnership strategies, and issues and solutions for health. In addition, students must learn how to practice using a feminist framework (Woods, 1995) that emphasizes the empowerment of individual women as well as the health and advancement of northern women collectively.

Students in the health care professions, including nursing, should be provided with opportunities to learn about the nature of northern practice generally, and practice with and for women in the north specifically. This will ideally be best achieved through health care education programs that are offered in northern settings. Such programs would aid recruitment and retention, as working in the north is more difficult for southern raised and educated professionals, and agencies may wish to hire locals who are more likely to stay in the north (Bjorkman, 1996; Delaney & Brownlee, 1996;

Foster, 2000). Northern-based programs increase awareness of the northern culture and health issues, and inform students about ways to effectively foster northerners' health. As desirable as these northern-based educational programs may be, however, their viability and quality may be compromised by the limited availability of appropriately prepared faculty and the increasing demand by universities nationally and internationally for these faculty.

This study revealed that access to continuing education for nurses and other health care practitioners regarding northern women's health issues may assist practitioners in providing more relevant and sensitive care to northern women. This education must be appropriate for northern needs and resources. Technology that facilitates access to education through the use of computers and advanced fibre-optic capabilities (Hanson, 1991) must be made available to northern health care practitioners. It is also recommended that southern resources, such as expert speakers and conferences, be brought to the north. This strategy helps to decrease the time and finances needed by northerners to travel, and demonstrates respect for the northern context. Moreover, this strategy exposes southerners to the north, thereby enhancing non-northerners' understanding of northern issues. As a result, health care policies and practices for northerners by northerners and non-northerners may more sensitively and appropriately address northerners' needs.

Conclusion

This study has sought to develop a theory about how women maintain their health in geographically isolated settings, specifically in northern British Columbia. Using a feminist grounded theory methodology, this study revealed a theory that articulates northern women's resilience in the face of often extreme adversity and hardship. The core problem of northern women in this study was vulnerability to health risks that resulted from their marginalized status within the northern context. The study identified an array of resilient strategies that northern women develop in response to these vulnerabilities, as well as factors that influence women's vulnerabilities and resilience. Women's efforts at developing resilience resulted in consequences of thriving, surviving, and declining in behavioral, cognitive, and emotional domains. Thus, this study provides a more comprehensive understanding of northern women's health than has previously been available. In addition, findings of this research suggest important implications for women's health research, health care practice and health-related policy, and health practitioner education. Nevertheless, further research is needed to enhance knowledge about the health needs and abilities of women who live in geographically isolated settings, and about factors that affect their needs and abilities. Further research in the north will help to enhance the health and health care of these women who live on the margins.

I close with a hope for the future, as aptly articulated by Park, a woman in this study who lives in a small northern BC town:

> I'm looking forward to the day when...society sees women's health as more than just the physical illnesses....There's more than...getting a sore back. And it's not just in women's heads....People [should] make the connection to other related environmental factors.

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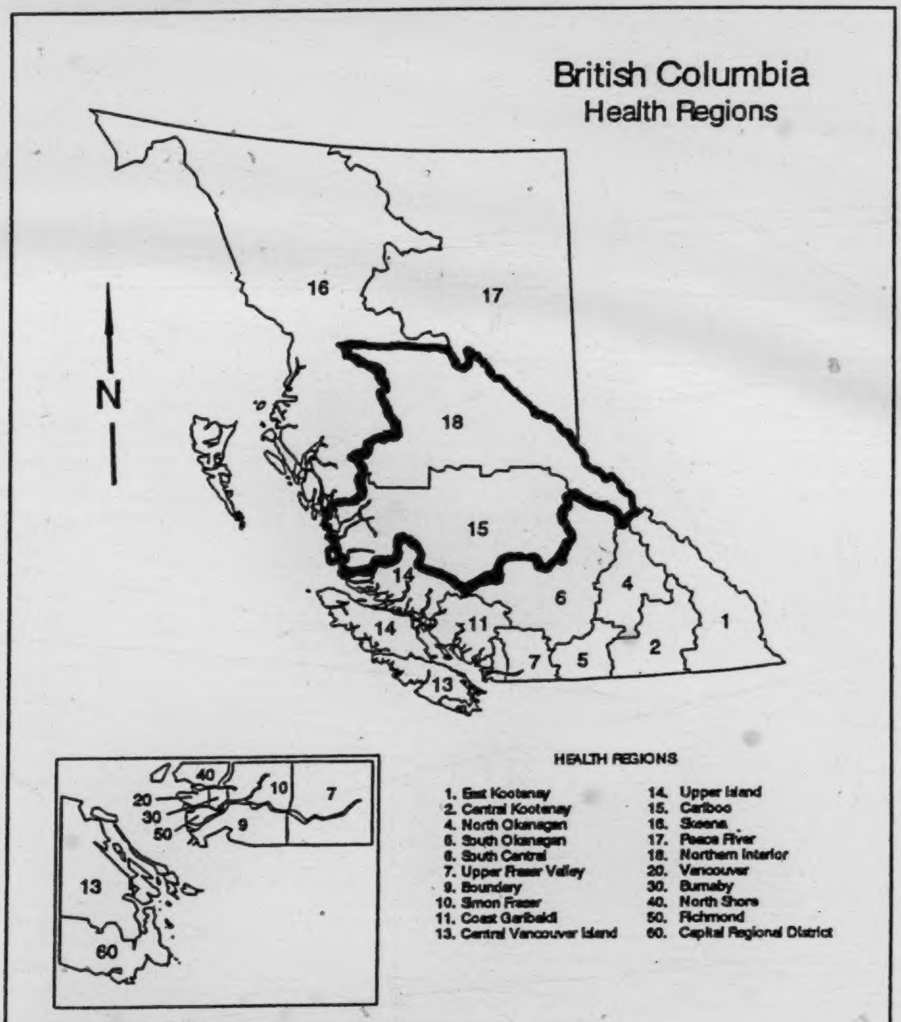
Appendix A: British Columbia Health Regions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HEALTH REGIONS
1. East Kootenay
2. Central Kootenay
4. North Okanagan
5. South Okanagan
6. South Central
7. Upper Fraser Valley
9. Boundary
10. Simon Fraser
11. Coast Garibaldi
13. Central Vancouver Island
14. Upper Island
15. Cariboo
16. Skeena
17. Peace River
18. Northern Interior
20. Vancouver
30. Burnaby
40. North Shore
50. Richmond
60. Capital Regional District

Prepared by: Health Economics & Planning Branch, Ministry of Health & Ministry Responsible for Seniors
Map Source: Central Statistics Branch, Ministry of Government Services

Enclosed bolded area denotes health regions included in this study.
Provincial Health Officer. (1996). Provincial health officer's annual report 1995. Victoria, BC: Ministry of Health.

Appendix B: Ethical Principles for the Conduct of Research in the North

Ethical Principles for the Conduct of Research in the North

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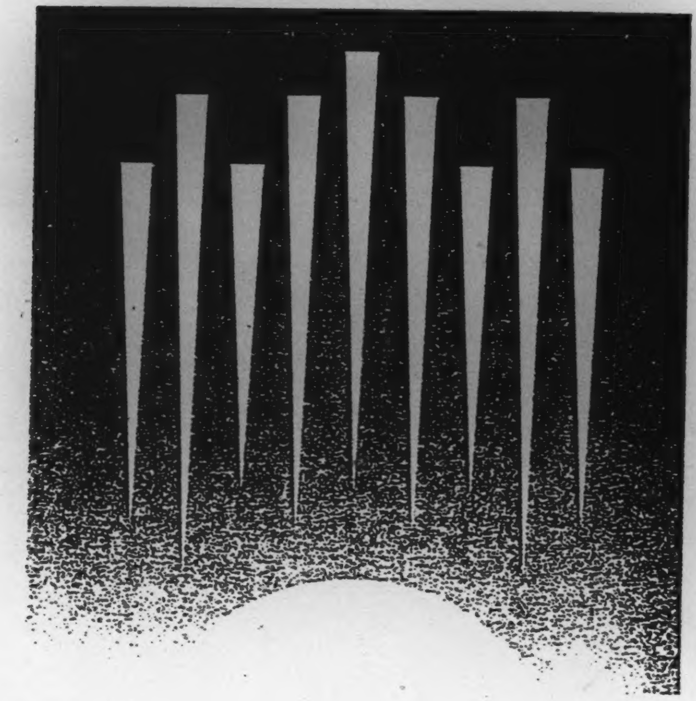
Principes d'éthique pour la conduite de la recherche dans le nord



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Association of Canadian Universities for Northern Studies

Association universitaire canadienne d'études nordiques

Ethical Principles for the Conduct of Research in the North

Preface 2
Introduction 3
Principles 5
Definitions 7
Applying the principles 8
Document history 9

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Principes d'éthique pour la conduite de la recherche dans le nord

Préface 20
Introduction 21
Principes 23
Définitions 25
Application des principes 26
Historique du document 28

Preface

Association of Canadian Universities for Northern Studies

Association universitaire canadienne d'études nordiques

Since 1982, the Association's statement of ethical principles for the conduct of research in the North has become one of the most widely disseminated and reproduced in Canada. Times, however, have changed in the North. Northern communities, governments, groups and individuals have pointed out that the principles needed adjustment to reflect developments in the North since then. We believe that the revised statement more accurately reflects the needs and concerns of northern communities and of the researchers who work there.

ACUNS maintains its commitment to the advancement of northern scholarship but recognizes that such scholarship and research take place among people with a stake in the work being done. Partnership is the by-word. Partnerships, however, must be founded on mutual understanding and trust. We see this revised statement of principles contributing to establishing that atmosphere. Many people helped to develop this revised statement and we wish to thank them all.

Amanda Graham,
Yukon College

Jim McDonald,
University of Northern British Columbia

ACUNS Board Committee
on Revising the Ethical Principles

Introduction

Since the publication of the Ethical Principles in 1982, they have proven their worth by becoming the most widely cited and adopted among northern researchers in Canada. Since then, however, the situation in the North has changed significantly. Many First Nations, the Inuvialuit, and the Inuit have settled land claims and, in many cases, related Self-Government Agreements. Land and other regimes have altered. Researchers now find the research context shifting, often unpredictably. Communities have sometimes found themselves and their concerns disregarded by researchers. A renewed research relationship has been called for and is emerging.

A new spirit of partnership between northerners and researchers is emerging in northern research. Of course, the nature of any particular partnership will depend on the specific project. The new partnership ethic, however, emphasizes the need to create meaningful relationships with the people and communities affected by research.

Another change is the increasing involvement of northerners not only as subjects or passive observers of research but in all aspects of the research process. Northerners are actively involved in research from conception to reporting, from funding to licensing.

For all parties to benefit fully from research partnerships, mutual understanding is critical. High quality research depends both on communities understanding the needs and concerns of researchers and on researchers understanding the needs and concerns of communities.

Guidelines, or principles, are needed to provide a foundation for and to foster a mutual understanding of community and researcher needs and goals and to ensure that research is carried out with the least friction and social disruption and the most co-operation and support.

The 20 principles presented here are intended to encourage the development of co-operation and mutual respect between researchers and the people of the North. They are also intended to encourage partnership between northern peoples and researchers that, in turn, will promote and enhance northern scholarship.

Northerners are involved with research in many different ways:

1. As researchers;
2. As members of a research team;
3. As partners in a research collaboration;
4. As research subjects;
5. As sources of information;
6. As users of completed research;
7. As clients;
8. As funders;
9. As licensors; or
10. As individuals experiencing and living with the impact of research.

If research is to be a positive component of the northern social and physical environment, it must respect and involve, where practical, northern residents in appropriate ways. To do so, the research must not only be explained clearly, conducted ethically, and used constructively, it must be guided by principles that consider all of the above-mentioned ways in which northerners may be involved in research activities.

Researchers must be aware that good intentions are not always sufficient for avoiding adverse reactions or effects of research. Mutual respect will develop from meaningful consultation and partnerships, and will work to advance northern scholarship of all sorts.

Principles

1. Researchers should abide by any local laws, regulations or protocols that may be in place in the région(s) in which they work.
2. There should be appropriate community consultation at all stages of research, including its design and practice. In determining the extent of appropriate consultation, researchers and communities should consider the relevant cross-cultural contexts, if any, and the type of research involved. However, incorporation of local research needs into research projects is encouraged.
3. Mutual respect is important for successful partnerships. In the case of northern research, there should be respect for the language, traditions, and standards of the community and respect for the highest standards of scholarly research.
4. The research must respect the privacy and dignity of the people. Researchers are encouraged to familiarize themselves with the cultures and traditions of local communities.
5. The research should take into account the knowledge and experience of the people, and respect that knowledge and experience in the research process. The incorporation of relevant traditional knowledge into all stages of research is encouraged.
6. For all parties to benefit fully from research, efforts should be made, where practical, to enhance local benefits that could result from research.
7. The person in charge of the research is accountable for all decisions on the project, including the decisions of subordinates.
8. No research involving living people or extant environments should begin before obtaining the informed consent of those who might be unreasonably affected or of their legal guardian.

9. In seeking informed consent, researchers should clearly identify sponsors, purposes of the research, sources of financial support, and investigators responsible for the research.

10. In seeking informed consent, researchers should explain the potential beneficial and harmful effects of the research on individuals, on the community and/or on the environment.

11. The informed consent of participants in research involving human subjects should be obtained for any information-gathering techniques to be used (tape and video recordings, photographs, physiological measures, etc.), for the uses of information gathered from participants, and for the format in which that information will be displayed or made accessible.

12. The informed consent of participants should be obtained if they are going to be identified; if confidentiality cannot be guaranteed, the subject must be informed of the possible consequences of this before becoming involved in the research.

13. No undue pressure should be applied to obtain consent for participation in a research project.

14. A community or an individual has the right to withdraw from the research at any point.

15. On-going explanations of research objectives, methods, findings and their interpretation should be made available to the community.

16. Subject to the requirements for confidentiality, descriptions of the data should be left on file in the communities from which it was gathered, along with descriptions of the methods used and the place of data storage. Local data storage is encouraged.

17. Research summaries in the local language and research reports should be made available to the communities involved. Consideration also should be given to providing reports in the language of the community and to otherwise enhance access.

18. All research publications should refer to informed consent and community participation, where applicable.

19. Subject to requirements for confidentiality, publications should give appropriate credit to everyone who contributes to the research.

20. Greater consideration should be placed on the risks to physical, psychological, humane, proprietary, and cultural values than to potential contribution of the research to knowledge.

Definitions

The principles refer to research in its broadest sense, including fundamental or applied research in the physical, biological, or social sciences. Surveys or monitoring studies would also be included. In general, research includes all technological activities in the North. Even mineral and petroleum exploration surveys would be expected to honour the general principles. However, the more detailed principles on informed consent are meant specifically for researchers whose work involves human subjects and might not apply to purely technological activities. The principles, however, hold that, where such activities might affect individuals or communities, there be consultation because the principles focus on the practical aspects of science that can affect local people, communities and the environment. Even where research does not involve local people in an obvious way, it may still have effects on the land, water or wildlife of the region, and may thus affect the people indirectly.

The word "community" is not restricted to a limited area of settlement. The surrounding land that supplies resources for the settlement and the people who live there are viewed as part of the community. In addition, there are communities of interest within geographical communities. These, too, should be considered where research activities might affect them.

The geographic area of concern includes the Yukon Territory, the Northwest Territories and its successors, Nunavut and the currently unnamed Western Territory, Northern Québec, Labrador, and the northern parts of the provinces from Ontario to British Columbia (the Extreme North, Far North and Middle North as defined by Louis-Edmond Hamelin (1975)). Although the emphasis is on isolated northern communities, the general principles are not unique to the North and most of them could be applied elsewhere.

Applying the Principles

In applying these principles to actual research, it is important to understand what they are not intended to do. They are not intended to regulate northern research—that is the responsibility of sponsoring organizations, northern governments or communities whose laws, guidelines and protocols will compel certain behaviour. And they are certainly not intended to be the last word on this matter. They are, instead, intended to guide the conduct of research in the North in general ways. They are conceived as general principles that will encourage research that is fair, honest, open and, where necessary, conducted with the consent and cooperation of whatever people or communities will be involved or affected or who might benefit or suffer harm from the research.

Some types of physical science or exploratory research might not appear to require the researcher to consider all the principles included here. This is a particularly important point. Research on physical phenomena at a distance from communities, traplines, hunting territories or traditional lands, might need nothing beyond the applicable permits. In other areas, the situation might require discussion of a project with a community. A researcher might not need to secure, for example, the informed consent of an individual as a participant or a subject in the research project. Nevertheless, the researcher might have to consider securing informed consent or an individual who might be a partner, a collaborator, or an informant, or of an individual or a community that might have to live with the effects of the research results or of its actual conduct (on community relations, game, land, water, etc.).

The situation in the North has changed considerably in the fifteen years since these Principles were first articulated and published. Both those who ask questions and those who help to supply the answers have new needs. Respect is vital in all aspects of the research enterprise. Respect for knowledge, expertise, world views, ways of life must flow in all directions. Genuine respect will enhance the research enterprise in the North and benefit all who live and work there.

Document History

These principles are based on "Ethical Principles for the Conduct of Research in the North" prepared by the Working Group on Canada/MAB Sub-Program 4 (Science for the North), March 1977. The ACUNS Committee on Relations with Northern Peoples studied the MAB document as well as ethical guidelines prepared by other groups, and presented its recommendations to the Association's Annual General Meeting in May 1981. The Committee's document was accepted by the ACUNS Council, subject to some amendment, responsibility for which was delegated to the Board of Directors. At a meeting on September 22, 1981, the ACUNS Board of Directors gave approval to the 1982 document.

In November 1995, the newly elected Board of ACUNS undertook to review the principles and to make recommendations for its change to the ACUNS Council. In November 1996, a two-person Board committee presented a discussion document to the Council at the Annual General Meeting. Comments on the document and, later, on a series of draft principles by researchers, academics, government officials, Aboriginal organizations, and research bodies as well as research into a variety of ethical guidelines produced by a host of other groups, associations, regulatory and research agencies, led to a draft of the revised document. It was presented to and accepted, with minor amendments, by the ACUNS Council at its November 1997 Annual General Meeting.

@ Association of Canadian Universities for Northern Studies, 1998.

Appendix C: Letters of Permission from Ethics Boards

Health Research Ethics Board

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UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES,
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date: April 1999

Name(s) of Principal Investigator(s): Ms. Beverly Leipert

Organization(s): University of Alberta

Department: Graduate Studies; Faculty of Nursing

Project Title: How Women Maintain Their Health In Northern Geographically Isolated Settings

The Health Research Ethics Board has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the patient information material and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval.

Sharon Warren

Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

UNIVERSITY OF NORTHERN BRITISH COLUMBIA
3333 University Way, Prince George, BC, Canada V2N 4Z9

Dr. Alex Michalos
Chair, UNBC Ethics Review Committee
Tel: (250) 960-6697 or 960-5820
Fax: (250) 960-5746
E-mail: michalos@unbc.ca

UNBC

UNBC Ethics Committee

May 26, 1999

Prof. Beverly Leipert
2nd Floor Adm.
UNBC

Proposal: 19990510.55

Dear Prof. Leipert:

The UNBC Ethics Committee met on May 19, 1999 to review your proposal entitled, "How Women Maintain Their Health In Northern Geographically Isolated Settings".

The Committee thanks you for your detailed proposal and endorses the approval of the University of Alberta's Ethics Board. You may proceed with your research.

If you have any questions, please feel free to contact me.

Sincerely,

Alex

Alex Michalos
Chair, UNBC Ethics Review Committee

Health Research Ethics Board

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212.11 Walter Mackenzie Centre
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p.780.492.9724 f.780.492.7303
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Edmonton, Alberta T6G 2G4
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ethics@rehab.ualberta.ca

UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES,
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date: April 2000

Name(s) of Principal Investigator(s): Ms. Beverly Leipert

Organization(s): University of Alberta

Department: Graduate Studies; Faculty of Nursing

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for Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

Health Research Ethics Board

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Date: April 2001

Name(s) of Principal Investigator(s): Ms. Beverly Leipert

Organization(s): University of Alberta

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Karen Turpin

for Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

Health Research Ethics Board

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UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES.
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date: April 2002

Name(s) of Principal Investigator(s): Ms. Beverly Leipert

Organization(s): University of Alberta

Department: Graduate Studies; Faculty of Nursing

Project Title: How Women Maintain Their Health In Northern Geographically Isolated Settings

The Health Research Ethics Board has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the patient information material and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval.

for Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

File number: B-010499-NSG

University of Alberta

Capital Health

CARITAS HEALTH GROUP

Appendix D

Information for Informed Consent for Interviews

Study Title: How Women Maintain Their Health in Northern Geographically Isolated Settings
Investigator: Beverly Leipert, RN, PhD Candidate, Phone: (250) 960-6510,
Fax: (250) 960-5536, E-mail: leipertb@unbc.ca
Sponsor: Faculty of Nursing, University of Alberta
Supervisor: Dr. Linda Reutter, Professor, Faculty of Nursing, University of Alberta,
Phone: (780) 492-5909, Fax: (780) 492-2551, E-mail: linda.reutter@ualberta.ca

Study Purpose: The purpose of this research is to learn how women maintain their health in northern British Columbia. I want to learn about how you think about your health and what you do to take care of your health. I also want to know about the factors that affect your health as you live in northern British Columbia.

Study Background: I am a nursing professor at the University of Northern British Columbia. I am working on a PhD degree in nursing at the University of Alberta in Edmonton. I am interested in women's health in northern and isolated settings. I want to learn what health means to women who live in northern BC. I also want to know how northern women stay healthy. I am interested to know how living in northern BC affects the health of women. I will also ask you for information about your background, for example your age, education, and occupation. Results from this study may help to establish services, programs, and policies that help women maintain their health. Results may also help women in northern BC think about their health and be better able to maintain and promote their health.

Study Procedures: I would like to talk with you two times. These interviews will occur either in your home or in another place we agree on. The first interview will last from one to two hours. The second interview will likely be shorter and may be by telephone. After these interviews, I will send you a summary of what was learned from all of the interviews. I will then telephone you to ask about your response to the summary.

I will tape record all of the interviews. What you say on the tape will be typed out. The only people who will listen to the tapes will be me and a typist. The typed notes may be seen by my supervisor and research committee. You may have a copy of your typed interviews if you wish. To protect your identity, only numbers will be used to identify tapes and transcripts of the tapes. The tapes, transcripts, and research notes will be kept in a locked file cabinet. They will be kept for a minimum of seven years after the research is complete.

Consent forms will also be kept in a locked file cabinet separate from the tapes, transcripts, and research notes. Consent forms will be kept for at least five years. Data may be used for another study in the future. I will receive approval from the appropriate ethics review committee before doing further studies with this data. Information and findings from this study will be published and presented at conferences. Your name or any other identifying information will not be used.

Study Participation: You do not have to be in this study if you do not wish to be. If you decide to be in the study, you may drop out at any time by telling the investigator. You do not have to answer any questions or talk about anything in the interviews if you do not want to. Being in this study or dropping out will not affect your care in a hospital, or in the community.

You will not be harmed as a result of being in this study. Nor do I expect that you will benefit directly from this study, although sometimes talking about your experiences can be helpful in thinking about your health. Sometimes talking about your experiences can be uncomfortable or can make you think about concerns that you have not dealt with. I will talk with you about this if it happens and assist you to find the help you need.

If you tell me any information about abuse of someone who is under 18 years of age, I will discuss this with you. This information cannot be kept confidential - I must report it to the British Columbia Ministry for Children and Families. If you agree, I will also contact a community health nurse and ask her to visit you.

Contacts: If you have any questions or concerns about any part of this study, you may contact me at the above address, or you may contact by collect telephone Dr. Janice Lander, Associate Dean Research, Faculty of Nursing, University of Alberta, (780) 492-6832. Dr. Lander is not part of this study.

Appendix E

Informed Consent Form for Interviews

Part 1 (to be completed by the Principal Investigator):
Title of Project: How Women Maintain Their Health in Northern Geographically Isolated Settings

Principal Investigator: Beverly Leipert, RN, PhD Candidate, Telephone: (250) 960-6510,
Fax: (250) 960-5536, E-mail: leipertb@unbc.ca

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand that the research interviews will be tape recorded?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care in a hospital or in the community.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to the information you provide?	Yes	No

This study was explained to me by: ______________________________

I agree to take part in this study.

______________________________ Signature of Research Participant

______________ Date

______________________________ Witness

______________________________ Printed Name

______________________________ Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

______________________________ Signature of Investigator

______________ Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix F

Consent Form for Permission to Take Photographs

This form provides opportunity to choose any or all of the following alternatives in relation to publication of photographs. Even though your identity may be included in some photographs, your name or places where you live and work will *not* be identified. Please sign under any or all of the following to which you agree:

I give permission for photographs of myself and my home and workplace, taken by Beverly Leipert, to be published:

1. In her dissertation document:

Participant's Signature	Witness's Signature
Participant's Printed Name	Witness's Printed Name

2. In article(s) which may be published in (a) scholarly journals(s) or in other documents; the purpose of these articles will be to share the findings of this study and assist others to learn about the health needs of women in northern geographically isolated settings:

Participant's Signature	Witness's Signature

3. In print or slide form to be used in presentations to present the findings of this study and assist others to learn about the health needs of women in northern geographically isolated settings:

Participant's Signature	Witness's Signature

Date: ____________________

Appendix G

Recruitment Invitations

On this page is information I developed for use on a poster, and for newspaper publication. On the next page is information I compiled for a radio show where I was interviewed.

Women's Health Research in Northern BC

Your help is needed for research about how living in the North affects women's health. Beverly Leipert, a professor in the Nursing program at UNBC, is conducting this confidential research.

Who is Needed?	Women who are 20 years of age or older Women who live in the Cariboo or Northern Interior Health Regions Women who have lived in the north for 2 years or more
What?	Interviews will be done by Beverly Leipert. You will be asked about how living where you do affects your health. You will also be asked about how northern women's health can be strengthened.
How Long?	The interview will last 1 to 2 hours.
Where?	Your interview can take place in your home community, or at UNBC.
Why?	This research seeks to strengthen the health of northern women. Findings will be shared with women, health policy makers, and health care practitioners at local, provincial, and national levels.

Interested?   Like more information?

Please call Beverly Leipert collect at **(250) 960-6510.**

Brief Biography and Potential Questions for the Bruce Strachan Radio Show

May 5, 1999

I. **Guest:** Beverly Leipert

- a nursing professor at the University of Northern BC in Prince George
- is a member of the Northern Secretariat of the BC Center of Excellence for Women's Health which is located at UNBC. The Secretariat focuses on women's health research in northern BC.
- currently conducting a study about how living in the north affects women's health
- has been a registered nurse for 22 years and has worked in rural and urban settings. Specialty area is community nursing.

II. **Potential Questions**

1. Could you tell us about your study and why it would be important for women in northern BC?

2. How will the study be done?

3. Are you still looking for more participants and what are the requirements to participate?

- be 20 years old or older
- have lived in the north for 2 or more years
    - the study focuses on women in the Cariboo and Northern Interior regions - from 100 Mile House north to Mackenzie, west to Burns Lake and east to the Alberta border.
- I would like to talk with women from a variety of backgrounds, including women who may have not traditionally been included or involved in research. For example:
    - elderly women
    - women with physical challenges or disabilities
    - women from various cultures (Aboriginal, Sikh, etc.)
    - rural women such as women who live on farms and ranches
    - women with various educational and economic backgrounds
    - women with various social backgrounds - partnered, not partnered, women without children as well as women with children, etc.

4. How much time does it take?

5. Where will the study take place? Do women have to come to Prince George or to the university to be interviewed?

6. How can our listeners contact you for more information? **Telephone me collect at (250) 960-6510 or email me at leipertb@unbc.ca**

Appendix H

Initial Contact Form

Name:

Telephone numbers: (home)

(work)

Fax:

Email address:

Address:

Background and other relevant data:

Appendix I

Background Information Form

Participant Information **Research Code:**_________

Age (in years): ______ **Years in the North** ______

Cultural Background:_____________________________

Education

<Grade 9 ____ Grade 9-13 ____ Trade or technical certificate/diploma ____

University undergraduate degree ____ University graduate degree ____

Occupation:_______________________________________

Hours worked each week ________

Full-time ____ Regular part-time ____ Irregular or casual part-time____

Health: How do you rate your health? Please circle one of the following:

Good Fair Poor

Family membership (Total number in household, gender, age, relationship)

____

____

____

____

Partner's Information (if applicable)

Age (in years): ______

Education

<Grade 9 ____ Grade 9-13 ____ Trade or technical certificate/diploma ____

University undergraduate degree ____ University graduate degree ____

Occupation:____

Hours worked each week________

Full-time ____ Regular part-time ____ Irregular or casual part-time____

Health: How do you rate your partner's health? Please circle one of the following:

Good Fair Poor

Annual family income (in $1,000's):

<10 ____ 11-20 ____ 21-30 _____ 31-40 _____ 41-50 _____

51-60 _____ 61-70 _____ 71-80 _____ 81 or greater _____

Appendix J

Initial Interview Guide

1. Would you first please tell me a little about your life, were you were born and grew up, and how you came to live here?
[This information will provide biographical and background information that will help me understand each women's situation.]

2. Would you please tell me about what it's like living here? What kind of work do you do? What do you do for fun and to relax? How does living here help you do the things you want to do? How does living here not help you do the things you want to do?
[These questions will help to obtain contextual data about participants' lives.]

3. What does the word "health" mean to you?
[This general type of question will illicit each participant's meaning of "health".]
Probing may need to be done to help women articulate their meaning of health; the following probe questions could be asked:
i) How would you describe your health?
ii) Could you be healthier? Less healthy? How?
iii) How do you know when you are healthy? Not healthy?

4. How do you stay healthy?
i) What kinds of activities or decisions help you stay healthy? How does living here benefit or contribute to your health?
ii) How does living here hinder your health? What do you do to cope with this? What would you like to be able to do about this, but cannot? What hinders you from doing something about these health issues?
[Probes could include: How do people in your life, such as family and friends, affect your activities and decisions about staying healthy? How do time, location, or financial factors affect how you stay healthy? If participants have moved to the north from other areas, they could be asked how living in northern BC is different, and how this difference affects their health.]

5. What suggestions do you have about how northern BC could be healthier for women?
[Probes might include: If you were the Minister of Health and had the authority and money, how would you improve the health of women in northern BC?]

6. What advice would you give to a woman who is moving north about how to stay healthy in the north?

7. Is there anything else that you wish to add?

8. Now that the interview is over, I want to confirm that you are still willing to let me include your interview in the study. Are you still willing to let me include your interview in the study?

9. To keep you name confidential, would you please select a name that I can use instead of your real name.

Thank you for sharing your thoughts and ideas with me. If you want to change or add to the information you provided in this interview, please telephone me collect at (250) 960-6510.

Appendix K

Field Notes Recording Form

Name of Participant:	First contact:_________ Second contact:_______ Third contact:________
Contact type: Visit:______ Phone:______	Contact date:______________ Today's date:_______________
Length of contact:	Others present:
Contact site:	

1. What were the main issues or themes that struck you in this contact?

2. Summarize the information you got (or failed to get) for this contact. Consider the target questions, environment, verbal & nonverbal data, quotes, your impressions, ideas for analysis, etc.

3. Anything else that struck you as salient, interesting, illuminating or important in this contact?
Consider the environment, verbal & nonverbal data, quotes, your impressions, ideas for analysis, etc. Any hunches, trends in data, emerging patterns? Any technological, methodological or other problems?

4. What new (or remaining) target questions do you have for the next contact with this participant/site?

This form was adapted from Miles & Huberman (1994, p. 53) and Morse & Field (1995, pp. 111-115).

Appendix L Individual Participant Characteristics

Participant Name	Age	Years in North	Health Region	Location
1. Vicky	59	12	Cariboo	Suburban[1]
2. Jocelyn	51	7	Cariboo	Suburban[2]
3. Casey	37	8	Cariboo	Rural[3]
4. Elizabeth	38	38	Cariboo	Urban[4]
5. Leah	21	16	Cariboo	Urban[4]
6. Amelia	56	53	Cariboo	Remote[5]
7. Christine	46	23	Cariboo	Urban[4]
8. Linda	36	26	Cariboo	Suburban[4]
9. Carmen	50	12	Cariboo	Urban[4]
10. Marie	56	25	Cariboo	Urban[4]
11. Eileen	48	24	Cariboo	Urban[2]
12. Park	40	25	Cariboo	Urban[2]
13. Rosie	59	26	Northern Interior	Remote[6]
14. Alice	47	11	Northern Interior	Rural[7]
15. Lillian	86	39	Northern Interior	Rural[8]
16. Barbara	44	44	Northern Interior	Urban[8]
17. Ruhi	20	3	Northern Interior	Urban[7]
18. Gert	38	38	Northern Interior	Urban[7]
19. Mary	47	36	Northern Interior	Urban[7]
20. Lilac	72	72	Cariboo	Suburban[2]
21. Fred	39	38	Cariboo	Urban[2]
22. Robin	59	58	Northern Interior	Rural[7]
23. Margaret	69	69	Northern Interior	Urban[7]
24. Signe	72	47	Northern Interior	Urban[7]
25. Rhoda	60	27	Northern Interior	Rural[7]

The footnotes indicate that women lived in or near the following communities:

1 Population - approximately 300
2 Population - 8,600
3. Population - under 100
4. Population - 11,400
5. Population - approximately 200
6. Population - 14
7. Population - 85,000
8. Population - 1,300

Appendix M

The following summary of the Northern Women's Health Gathering was prepared by Leanne Jones of the Creating Solutions project.

The Northern Women's Health Gathering:
Creating Solutions: Researchers and Women in Action

By October 2000, the women of Creating Solutions had reached the point in their research journey where action was the next step. The National Health Summit, slated to take place in Prince George in January 2001, proved to be the perfect opportunity to put into practice the empowerment they all gain through the research process.

The women watched the developments of the summit agenda unfold on its website and saw that First Nation's and women's issues were not represented. The women decided that their voices and the voices of women in north must be listened to regarding health issues. They knew as a result of the research that women experience health and health care differently than men. Social issues and mental health are two of the greatest determinants of health for women, yet neither issue was to be addressed at the supposed 'National Health Summit.' This fact was simply unacceptable. Something needed to be done.

The women decided that a demonstration addressing the marginalization of women's health issues would be an empowering and effective way to get their message out. Women from Creating Solutions contacted the summit organizers, met with them to express their desire to be respectful of the summit organizers process, and hoped for a reasonable solution to the problem. The summit organizers expressed their concerns that the women's demonstration may reflect badly upon their work. Viewing this as an opportunity to create change, the women suggested presenting their findings, and speaking to women's and First Nation's issues at the summit.

Unfortunately, and quite predictably, the women were not granted access to the summit (the cost was $214 per person), nor were they given the opportunity to present their findings at the summit.

And so, the birth and creation of the 'Women's Health Gathering' ensued. The event was to take place as **free** alternative to the National Health Summit. The intention was to invite as many women as possible to march to the Civic Centre thus drawing attention to the agenda of the summit. The 'gathering' portion of the event was to provide an opportunity for women to tell each other their stories, nourish their minds and bodies, and gather recommendations for women's health and present them to the National Health Summit.

During the planning process, the event drew media and government attention. Corky Evans, the Minister for Health in British Columbia, both contacted the women and subsequently made a brief but supportive appearance at the gathering. The women of Creating Solutions learned many valuable life lessons regarding how the media operates. There was a great deal of back and forth 'negotiations' with the media in Prince George before a story that closely represented the truth about the Women's Health Gathering was printed.

After many days of hard work, stress and emotion the Women's Health Gathering took place on January 19, 2001. It was attended by approximately 60 women during the day and proved to be an enormously gratifying success. Many women found the courage that day to stand up to the microphone and tell their personal and often heart-wrenching stories of abuse at the hands of the medical profession.

Women spoke, networked, nourished themselves both physically and mentally (there was a great lunch provided J), found entertainment, laughed and cried. At the end of the day many recommendations addressing better health care for women were complied. The next day the recommendations were taken to the National Health Summit and were included in a local task force which had been set up to address health issues in the north.

The process was very empowering, enlightening and useful as a means of influencing social change. The women of Creating Solutions proved that women have the ability and the right to create their own powerful opportunities to have their voices heard.

Leanne Jones
For Creating Solutions

Recommendations made by the Women's Health Gathering
January 19, 2001 Prince George, BC

Recommendations for policy makers, doctors and health care providers:

Ø All doctors should exemplify appropriate conduct with each individual patient's concerns.

Ø Don't treat the patient as if the doctor knows all and is a God to be listened to. Especially when the doctor is not qualified with that expressed problem. LISTEN to patient and give proper information to the patient.

Ø Make information more available to women so they can research their illness. Have doctors be trained so that they are more aware of alternate medicines ways of healing.

Ø Arrange alternate methods of finances when patients need to leave their communities for treatment.

Ø Health education in the north is important – prevention – health promotion oriented not more doctors.

Ø Greater use of nurse practitioners to take over traditional role of physicians so that women in remote rural areas have access to respectful, equitable healthcare.

PROVIDE CORE FUNDING TO COORDINATING COMMITTEES ON VIOLENCE AGAINST WOMEN.

Ø To integrate health and anti-violence work.
Ø To free up health care workers' time to do the work of co-ordinating communities, including attending committee meetings.
Ø To raise awareness and skills of health care workers with issues of violence against women.
Ø Develop best practice for agencies that deal with women around mentioning abuse; especially if they don't normally deal with violence and abuse.
Ø Develop contacts by phone for women who live in isolation. (N.A. and A.A. have phone lines for those who live in the north.

Aboriginal Elders:

I know many women who have had to live in hospitals away from communities, culture, roots, and family, everything they know and die in white rooms, alone sometimes.

Solution:

- Centers in villages, more training for CHRS/home support workers, cultural education for Doctors / Nurses who are servicing aboriginal people away from their homes.
- Provide us with more information on detoxification when we have to come off harsh medications.
- More health education for women.
- Honour women in the various health services; validate their experience and abilities.
- Health education for women provided by nurse practictioners.
- Teach us how to find alternative funding sources and options.
- Real data, questions, solutions and answers regarding lesbian and bisexual health issues including cross cultural perspectives.
- More feminist research methods used for determining unique lesbian and bisexual health concerns.
- Realize access barriers to health care for lesbian and bisexual women such as heterosexism and homophobia.
- Help doctors develop better listening skills and a touch of empathy!
- Give us a road map of medical services that are available in our communities.
- Find research alternatives i.e. conduct research on women for women's health.
- Take a wholistic view to medical services and practices. Consider all aspects of women's lives in diagnosis and caregiving.
- Give us more money to research preventative measures for young girls especially for those in Northern and remote areas.
- Create a symptoms line where you can call up, discuss the symptoms and be told if you need to see a doctor or not.

I just wanted to say that certainly for women's health care, and health care in general, there needs to be a more proactive and preventative attention to health. Merely treating illness, disease and health-related problems does not equal health. Health is nutrition, environment, emotional positivity, and social connections – it means having a voice and understanding within personal and community health issues.

- Health is a right, is should not be governed by class, sexual orientation, race, and access to material wealth.
- Doctors should be trained to treat people rather than patients.
- Doctors and medical practitioners need the support to help support others.
- Doctors need to be respectful to women's health.
- Need a women's health care clinic
- Alternative care / traditional – easier to access.

- Women's health care provided (expand nurse's roles) by women.
- Access to mental health – realistic, feminist based.
- Provide more women's issues workshops – menopause, breast cancer.
- We need easy access to information on alternative health recommendations from physician's offices.
- We need a Women's Health Clinic in Prince George (non-hierarchical, feminist, egalitarian, non-racist, non-classist).
- Prince George needs more women friendly places to go i.e. women's resource centre etc…
- I think there needs to be greater understanding of depression and women and how it correlates with lack of power and women.
- Doctors and other health care providers need to address these issues by not giving women antidepressants without recommendations to counsellors or women's groups etc…
- Depression is not just a 'chemical imbalance' but a lack of power and a lack of voice being heard in society, community and with health care providers.
- Recognize that women are the experts on their own health and bodies.
- Create partnerships with the healthcare professionals.
- Teach doctors to take the time to listen to you instead of making you feel rushed.
- We want more female doctors.
- Learn from innovations of northern women who are informal caregivers – survival tips – innovations despite being in extremely difficult circumstances.
- The need for support (financial / social) for older women to live out their lives in the north.
- There should be some type of appeal process whereby the patient can disagree with doctor's diagnosis so that the quality of care is foremost i.e. doctors that push pills, having a second opinion as an option.
- Specific training for health care providers (all of them) that would focus on respect first and viewing the individual as the expert on their own concerns with the health care provider as a consultant – not the expert.
- Specific action taken against the DSMIV as one of the most misogynist documents out there. In particular, how women are written off for behaviours, feelings, responses, that came as a result of abuse and trauma – the final abuse being the 'borderline personality' label.
- Male doctors tend to brush off medical concerns as 'you're getting old, you have to expect these things.'
- Doctors put limits on the number of symptom's to be discussed. So which symptoms are relevant?
- Doctors give medical advice not appropriate for the patient (economic, fear, etc) then label that patient as non-compliant

Recommendations for Women:

- Get to know your Pharmacist.
- More support groups and talking circles.
- Keep gathering and discussing these issues.
- Learn how to be an advocate for yourself and others.
- Use the internet
- Keep asking questions even when you seem to hit roadblocks.
- Take charge of your own health.
- It is not just in our heads.
- BE PERSISTANT
- Get second opinions
- Be mindful of the information you divulge to your doctor, sometimes can create biases.
- Work towards a society where we can speak freely about who we are and the experiences we've had without shame.
- Nurture our family support systems.
- As preventative measures we need to empower young girls.